INDIGENOUS SERVICES CANADA

Phase One Evaluation of the Mental Wellness Program

Draft Phase One Final Report

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Indigenous Services Canada | Services aux Autochtones Canada

Canada

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List of abbreviations and acronyms

AFN	Assembly of First Nations
CBRT	Community-Based Reporting Template
EAG	Evaluation Advisory Group
FNMWCF	First Nations Mental Wellness Continuum Framework
FNIHB	First Nations and Inuit Health Branch
GBA Plus	Gender-based Analysis Plus
IRS RHSP	Indian Residential Schools Resolution Health Support Program
ISC	Indigenous Services Canada
ITK	Inuit Tapiriit Kanatami
MWP	Mental Wellness Program
MWT	Mental Wellness Team
NISPS	National Inuit Suicide Prevention Strategy
NNADAP	National Native Alcohol and Drug Abuse Program
TB	Treasury Board
2SLGBTQIA+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and additional people who identify as part of sexual and gender diverse communities

Executive Summary

Background

Between 2015-2016 to 2020-2021, the First Nations and Inuit Health Branch (FNIHB) within ISC provided funding and support for mental wellness programs and services for primarily First Nations and Inuit, which are delivered predominantly on-reserve, and in Inuit Nunangat. In many cases, services and programs are delivered directly by First Nations and Inuit communities and organizations, along with non-governmental organizations. During this timeframe, the Mental Wellness Program (MWP) funded a wide range of mental wellness services that included:

- Trauma-informed health and cultural supports for Survivors and Intergenerational Survivors of Indian Residential Schools and Federal Indian Day Schools, as well as those impacted by the tragedy of missing and murdered Indigenous women, girls, and 2SLGBTQIA+ people.[1]
- Substance use treatment
- Community-based supports, including:
    - Life promotion, suicide prevention, and crisis response
    - Substance use prevention
    - Mental wellness teams
    - Opioid agonist therapy wrap-around sites

The MWP is guided by foundational partner frameworks including the First Nations Mental Wellness Continuum Framework (FNMWCF), Honouring Our Strengths, and National Inuit Suicide Prevention Strategy (NISPS). In-line with these frameworks, changes were made within the program during the evaluated period by consolidating many community-based funding streams to reduce siloes, increase flexibility, and better support communities in addressing priorities and meeting needs.

Evaluation Scope and Methodology

The evaluation focused on the period of 2015-16 to 2020-21. Input was sought from an Evaluation Advisory Group (EAG) which included First Nations and Inuit partners, to support the design and conduct of the evaluation. This evaluation report covers the first phase of what is expected to be a two-phase process. This initial phase had a Governance-level focus that was limited to national and regional-level perspectives on key issues and included a recommendation regarding the need for an additional phase of work that will be Indigenous-led and community-focused. At the time of writing this report, discussions were underway to advance the second phase of study.

In line with the Treasury Board *Policy on Results* and Section 42.1 of the *Financial Administration Act*, the objective of the first phase of the evaluation was to assess the relevance as well as the performance in terms of effectiveness, design, delivery, and efficiency of MWP funding and support for First Nations and Inuit in alignment with the mandate of the program. The evaluation also covered thematic areas and priority issues relevant to the program, partners, and to the broader department, including service transfer, the COVID-19 pandemic, climate change, children, youth, and families, and impacts through a gender-based analysis plus (GBA plus) lens.

[1] Trauma-Informed Health and Cultural Supports are available to eligible individuals, regardless of Indigenous status and place of residence within Canada.

The evaluation focused on both First Nations and Inuit contexts (i.e., services on-reserve and in the North) through engaging national and regional representatives (e.g., regional organization representatives).[2] A mixed methods approach was utilized, involving the following data sources:

Literature Review (leverage expertise and contextualize the MWP)	**Document and Data Review** (review foundational program documents and reporting data)	**Key Informant Interviews** (48 interviews: First Nations and Inuit national and regional representatives, treatment centre representatives, FNIHB staff)

Main Findings

Program Relevance

The MWP remained highly relevant and there was a great need for ongoing and adequate funding. Supports and services funded through the MWP are needed to address the enduring legacy of settler colonialism and to support good health and well-being for First Nations and Inuit across the lifespan. Many factors drove increased demand on the programs/services funded through the MWP, including continued growth in demand, the COVID-19 pandemic, re-activation of trauma,[3] the toxic drug supply and continuing overdose crisis. As well, the evaluation timeframe was marked by greater discussion of mental wellness and awareness of the experiences of survivors (including, Survivors of Indian Residential Schools, Federal Indian Day Schools, the Sixties Scoop, and Missing and Murdered Indigenous women, girls, and Two-Spirit people). Almost all key informants (FNIHB, Inuit, First Nations) agreed that the funding through the MWP was relevant to the priorities of First Nations and Inuit, owing to its improved flexibility (particularly through the Mental Wellness Alignment), recent funding enhancements, and investments in key issues identified by partners. A few indicated that funding could be more aligned through attention to capital needs and priority populations (shown below).

Areas of Program Alignment	Opportunities for Greater Alignment
• Having increasingly flexible program terms and conditions supported community autonomy. • Funding enhancements were received in priority areas. • Undertaking efforts to understand and align with partner and regional priorities	• Need for funding for capital/infrastructure expenses limited program opportunities. • Some felt that there were populations that were not adequately "covered" through program funding (i.e., children, youth, families)

Effectiveness

[2] For clarity, "representatives" and "key informants" are used interchangeably throughout the report to describe individuals that participated in semi-structured interviews with the evaluation team, which informed the evaluation findings and report.

[3] Announcements of unmarked burials at the site of the former residential school at Tk'emlupss occurred shortly after the evaluation timeframe; however, discussions with partners and program representatives highlighted the significant impact of this event and those that followed.

Program performance data show that access to and uptake of services greatly increased over time, including through the Indian Residential Schools Resolution Health Support Program (IRS RHSP), treatment centres, Mental Wellness Teams (MWTs), and additional opioid agonist therapy (OAT) wrap-around services.

Indicators of Program Uptake

IRS RHSP: 57% increase in number of counselling hours between 2015-2021

Treatment Centres: Increase in admittance numbers for most services and client groups

MWTs: 50% of First Nations and Inuit communities with access by 2019-20 (increase from 15% in 2015)

OAT: Number of ISC-funded wraparound supports at OAT sites grew from 15 (2017) to 72 (2020)

Key informants and existing research suggest that MWP funding contributed to the delivery of responsive services that were integrating culture, trauma-informed, strengths-based, and evolving to meet the needs of populations reached through the program. Findings from Phase One suggest that while these services were contributing to the broader continuum of care, challenges remained across regions, including access to culturally safe provincial medical detox services, case management, and treatment centres and community substance use programming. Key factors that appeared to affect implementation of a coordinated mental wellness system include:

- Lack of provincial/territorial partnership and investment
- Need for additional funding
- Human resource capacity, and
- Limited facilities/infrastructure in some communities

Design, Delivery, and Efficiency

A key change to the MWP was the introduction of the Mental Wellness Alignment in 2020, which enabled greater flexibility for those in Set and Fixed Agreements to plan and deliver programs holistically with streamlined reporting accountabilities. Some felt that the support offered through the MWP could be improved through addressing internal management concerns (e.g., turnover, misplaced funding reports within FNIHB), strengthening communication (e.g., related to the Alignment), focusing on consistency in reporting requirements, and improving intra-departmental collaboration. Indeed, while the departmental transfer of FNIHB from Health Canada to ISC fostered alignment and a common vision, key informants felt that opportunities to collectively advance key issues (e.g., the social determinants of health, children and youth) had not been maximized.

Despite program enhancements (e.g., 56% increase in contributions spending), there was strong agreement that the available financial resources within the program did not meet the demand for services. The following constraints were identified as it related to program funding:

- **Increased need/demand:** Key informants felt that funding had not kept pace with factors including population growth, inflation, competitive wages, and increased program demand.

  Sustainability: According to MWP staff, about half of total program funding was time limited. As well, though the program received additional funding during the evaluation timeframe, an estimated $437.9M per year was time limited funding that would need to be renewed. Lack of sustainable funding creates challenges for communities and service

delivery organizations. Examples of where these challenges lie include recruiting and retaining staff, forward planning, program development, and mental wellness promotion

- **Growth:** Less than half of MWP funding included a 3% annual escalator at the start of the evaluation timeframe (2016), and funding received in later years did not have escalators attached to it, making it difficult for communities to keep pace with rising costs.

Alongside improving funding approaches,[4] key informants recommended enhancing support for the mental wellness workforce in collaboration with national partner organizations such as through a dedicated workforce strategy, mentorship and laddered training, and focusing on knowledge sharing.

Thematic Areas

Children and Youth

Despite several funding streams having the flexibility to support First Nations and Inuit children, youth and families, greater supports for these groups, including through enhanced mental wellness prevention and early identification was a common priority identified within First Nations and Inuit contexts. Examples of how this could be supported included more resiliency-based programming, in-school counselling supports, land-based activities, and treatment centre services.

Some felt that there had been limited targeted funding within the MWP for children and youth and that there was a lack of coordination across the department, leading to youth "falling through the cracks." Regionally, First Nations and Inuit also explained that meeting the needs of children, youth, and families can be impeded by a lack of available facilities/infrastructure, limited funding to invest in population-specific programs, and limited capacity of staff to plan and deliver programs. These challenges can be amplified for remote and isolated communities, in particular.

Climate Change

Notwithstanding the considerable diversity in worldviews, knowledges, perspectives, and contexts of First Nations and Inuit, climate change has disrupted many of the determinants of well-being for Indigenous peoples, including engaging in land and culture-based activities, access to traditional medicines, sharing knowledge across generations, and food security. Furthermore, evacuation events have led to increased stress, grief, and relocation to environments that are not conducive to the well-being of community members and those attached to services.

Regionally, MWP representatives, MWTs, and Health and Cultural Support Workers have supported emergency efforts through crisis response efforts, service coordination, and setting up pop-up services. Recognizing the increasing threat of climate change events and the close connection with mental wellness, a continuing increase in demand for services may be expected. Representatives agreed that collaboration efforts should increase alongside communities/organizations and with Health Emergency Management.

Service Transfer

The MWP undertook efforts to support self-determination and First Nation and Inuit control over mental wellness services. This included offering more flexibility in funding agreements by

[4] More specifically, key informants spoke to the need to ensure that funding approaches reflect demand/access of services, support long-term planning and sustainability, ensure wage equity, and include growth over time to reflect changing costs of program/service delivery.

consolidating funding envelopes, streamlining reporting, supporting Indigenous partner-led workforce development, and focusing on de-centralized decision making through regionally-based partnership structures.

The stated primary barrier affecting the journey towards service transfer was the need for additional and sustainable funding to enable communities to deliver a suite of holistic programming, retain qualified staff, stabilize and restore capacity, access training, and engage in long-term planning. Further to this, funding stipulations and specific reporting requirements committed to central agencies were seen as inconsistent with the department's mandate, alongside a lack of internal collaboration/integration. While there is no one "best practice" to fostering service transfer, key informants and supporting literature reported promising practices that can facilitate this vision, including ensuring appropriate funding (e.g., adequate, sustainable, flexible, long-term, simplified), restoring capacity and supporting workforce development, and supportive partnerships (e.g., between federal government/departments, First Nations and Inuit, and provincial and territorial representatives).

The COVID-19 Pandemic

Numerous challenges were introduced or enhanced by the pandemic, including worsening of mental health and exacerbation of inequities in the social determinants of health, service limitations, rising acuity of needs, and population-specific impacts. Communities were supported to adapt and expand mental wellness services through a temporary influx of flexible funding among other measures. Commonly, communities and organizations introduced or enhanced land-based programming, adapted existing programs to address public health measures, and/or introduced virtual programming.

The broad funding authorities and influx of flexible funding were seen as strengths to mitigating the impacts of the COVID-19 pandemic. However, the time-limited nature of funding necessarily meant that communities could not continue with programs despite demands and evidence of success and need.

Phase One Recommendations

Based on the findings of this evaluation report, it is recommended that ISC should undertake the following efforts/actions:

1. **Indigenous partner-led Phase Two Study:** ISC should support an Indigenous-led second phase of study that focuses on First Nations and Inuit community voices that were not captured within Phase One.

   As community-based perspectives were not gathered in the current evaluation study, it will be important to engage with funded communities/organizations who reflect a wide diversity of contexts, in order to gain a comprehensive understanding of the MWP and its future directions. This second phase of study should complement the regular engagements that program officials undertake with Indigenous partners, and focus on areas in which additional information from community perspectives is most needed, such as those not covered in recent Indigenous-led studies.

2. **Collaboration:** ISC should review and identify measures to advance a) intra-departmental; and b) regional collaboration to better address the complex and multi-

faceted challenges present within mental wellness (e.g., the social determinants of health, Health Emergency Management planning, children and youth).

Findings from Phase One point to the complex and multi-faceted nature of mental wellness (Finding 1) and the coordination challenges within the department and regionally (i.e., between FNIHB, First Nations and Inuit partners, and provincial and territorial representatives) (Finding 4, 7, 9, 11). Exploring opportunities to increase intra-departmental (i.e., horizontal) collaboration to focus on coordinated action could support advancement of key issues identified in Phase One (e.g., social determinants of health, Health Emergency Management, children and youth). Further to this, continuing to advance coordinated and collaborative regional partnerships (i.e., with First Nations and Inuit regional partners and provincial and territorial health system representatives) is important to collectively addressing the continuum of mental wellness services, reducing duplication, and achieving progress in reducing health inequities.

3. **Funding:** ISC should develop options for overcoming the program delivery challenges created by restrictions on capital spending and revisit and update as required the program's funding approaches, including with respect to the need for sufficient ongoing funding with appropriate escalators, and the appropriate distribution of available funds. .

Funding remained a key barrier to addressing demand and achieving outcomes (Finding 8). Several issues were outlined by key informants: funding had not kept pace with needs, some restrictions (i.e., capital) limited the delivery of programs, not all funding was eligible for growth, and the time-limited nature of some enhancements did not enable sustainable planning and delivery. Therefore, there is a great need to continue to focus on, and advocate for, funding that is adequate, sustainable, equitable, flexible (including: facility/capital needs), and long-term and which supports First Nations and Inuit to advance their priorities.

4. **Workforce development:** ISC should work collaboratively with First Nations and Inuit partners to explore opportunities/mechanisms that could further support workforce development and support an updated assessment of the impacts of competitive wages on workforce development and retention.

Findings from Phase One suggest that supporting the workforce is an area of priority and aligns with the broader vision of supporting service transfer (Finding 8, 12). The creation of a workforce strategy, mentorship and laddered training through an Inuit and First Nations lens could be opportunities for further exploration in this area. Additionally, greater insight on wages and compensation could augment communities' and organizations' ability to recruit and retain mental wellness professionals.

5. **Performance measurement:** ISC should work collaboratively with partners to identify opportunities to align performance measurement activities with community perspectives on wellness, ensure alignment between the logic model and indicators, and continue to fund partner-led research assessments to gather in-

depth and actionable insights on the program (e.g., important topics, issues, and population-specific considerations within the MWP) (Finding 10).

Working alongside First Nations and Inuit partners, performance measurement could be enhanced within the program through approaches that are culturally safe, trauma-informed, and in-line with distinct perspectives on wellness. Collaboration in this area, as well as resources, could improve the capacity of community-based staff to ensure adequate data systems, processes and strategies are in place to collect and use meaningful data. Attention should also be placed on improving the clarity and accuracy of the logic model, including the linkages between program activities, indicators and expected outcomes. A consistent logic model and indicator use, in addition to the associated reporting templates and data collection tools, can facilitate measurement. As well, it is recommended that the MWP continue to fund partner-led research assessments, which could contribute to improving outcomes.

Management Response and Action Plan

Evaluation Title: Evaluation of the Mental Wellness Program

Overall Management Response

Overview

This Management Response and Action Plan was developed to address recommendations presented in the Evaluation of the Mental Wellness Program. The MRAP was developed by Indigenous Services Canada's First Nations and Inuit Health Branch (ISC-FNIHB) in collaboration with the Evaluation Directorate.

ISC-FNIHB acknowledges and concurs with the recommendations outlined in the report of the phase one evaluation of the Mental Wellness Program conducted by ISC's Evaluation Directorate.

ISC-FNIHB is committed to supporting Indigenous Peoples on their journey towards self-determination and transferring control of services to Indigenous partners. ISC-FNIHB recognizes that mental wellness is a key priority for First Nations, Inuit, and Métis, and will continue to work with partners and communities to advance their mental wellness priorities.

The evaluation period coincided with a period of considerable change, both internal and external. FNIHB transferred from Health Canada to the newly formed Indigenous Services Canada; the mental wellness program consolidated a number of "sub-sub-programs" under a single umbrella "sub-program" in order to increase flexibility in program delivery and reporting; and the Covid-19 pandemic impacted mental wellness needs and the ways services were delivered.

ISC-FNIHB is committed to taking action on all of the recommendations and has already begun much of this work. It is also looking forward to hearing directly from Indigenous partners through the "phase two" studies, and to use the recommendations that emerge from that work to make further improvements.

In the time since the evaluation period, ISC-FNIHB has worked with partners to make changes which address many of the recommendations proposed in this report. Funding for the mental wellness program has more than doubled since the beginning of the evaluation period, with investments for new, enhanced, or renewed services in Budgets 2016, 2017, 2018, 2019, 2021, 2022, and 2024. In 2022, ISC-FNIHB hosted the first national mental wellness summit, which showcased Indigenous-led approaches to mental wellness and supported knowledge sharing and collaboration. We prioritized workforce development including providing funding for Indigenous partners to develop a workforce strategy and to explore the development of a mental wellness workforce association. We supported Indigenous-led approaches to evaluation including ~~by~~ funding two excellent pieces of work undertaken by the First People's Wellness Circle which used culturally relevant and appropriate methodologies to assess the impact of the Indian Residential Schools Resolution Health Support Program. Finally, we have been working at modernizing our approach to results through the development of a results framework that is organized around 4 pillars: availability, accessibility, quality, and effectiveness.

While we concur with all the recommendations, it is important to note that some elements of recommendation 3 fall outside of the direct control of the Mental Wellness Program. In particular, the Mental Wellness Program does not have ultimate control over annual program budget levels, funding profiles, or funding escalators. The response to this recommendation reflects actions that are within the purview of the program.

An annual review of the Management Response and Action Plan will be conducted by ISC Evaluation Directorate and shared with the ISC Performance Management and Evaluation Committee to monitor progress and activities.

Assurance

The Action Plan presents appropriate and realistic measures to address the evaluation's recommendations, as well as timelines for initiating and completing the actions.

Action Plan Matrix

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
1. ISC should support an Indigenous-led second phase of study that focuses on First Nations and Inuit community voices that were not captured within Phase One	We **do** concur. 1.1. Indigenous Services Canada will support an Indigenous-led second phase of study by providing funding for Indigenous-led and community-focused evaluations of treatment centres, mental wellness teams, and opioid agonist treatment wraparound services. (March 31, 2026, to be confirmed with the partners undertaking the work)	Director General, Mental Wellness and Health Promotion Directorate, FNIHB	Start Date: **01/01/2025** Completion: **31/03/2026**	**Status:** ☐ Fully Implemented ☐ Partially Implemented √ Implementation did not Commence ☐ Obsolete Indigenous Services Canada is committed to supporting Indigenous-led and culturally relevant approaches to evaluating mental wellness program funding and services. Aspects of the Mental Wellness Program have already undergone Indigenous-led evaluation and assessment. For example, the department provided funding for the First Peoples Wellness Circle to develop two evaluations of the impact of, and ongoing need for the Indian Residential Schools Resolution Health Support Program. The evaluations utilized culturally-relevant and trauma-informed approaches to engaging with Survivors, community members, service providers, and funded organizations. The two reports were published in 2021 and 2024. - Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories – Qualitative Assessment – First Peoples Wellness Circle (fpwc.ca) - Indian Residential School Resolution Health Support Program (IRS RHSP) Formative Analysis – First Peoples Wellness Circle (fpwc.ca) This work is also highlighted as actions under recommendation 4 and will be published alongside the phase two studies. Building on the important work undertaken by the First Peoples Wellness Circle, Indigenous Services Canada will work with Indigenous partners to evaluate the continued need, impact and effectiveness of three critical areas of the mental wellness program

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Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
				which have not recently undergone Indigenous-led evaluations and received increased funding during the evaluation period. Focused evaluations of federally-funded treatment centres; mental wellness teams; and wrap-around services at opioid agonist treatment sites will help the federal government and Indigenous partners to understand the impact of recent funding growth, identify emerging needs, and strategically plan for the future.
2. ISC should review and identify measures to advance a) intra-departmental; and b) regional partner collaboration to better address the complex and multi-faceted challenges present within mental wellness (e.g., the social determinants of health, Health Emergency Management planning, children and youth).	We **do** concur. Indigenous Services Canada will continue to collaborate with regions and sectors to address mental wellness needs in the context of the social determinants of health and other interrelated factors. 2.1 (a): Establish tracking system for Statements of Local Emergency, facilitating equal access to information, and improving opportunities for collaboration between the mental wellness program and other programs/ sectors which support emergency response (Completed, 2021). 2.2 (b): Host National Summits on Indigenous Mental Wellness (Completed, 2024).	Director General, Mental Wellness and Health Promotion Directorate, FNIHB	Start Date: **01/04/2021** Completion: **2.1: 01/04/2021** **2.2: 17/10/2024** **2.3: ongoing**	**Status:** ☐ Fully Implemented √ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete In recognition of the inter-connectedness of mental wellness with many other factors, Indigenous Services Canada has taken a number of steps to support better collaboration amongst sectors and regions. The mental wellness program is guided by key frameworks developed with and by Indigenous partners which describe the importance of the social determinants in understanding and improving First Nations and Inuit mental wellness. The department provides funding for the implementation of the National Inuit Suicide Prevention Strategy and participates as a member of the implementation team for the First Nations Mental Wellness Continuum Framework. In 2022, 2023, and 2024, the department hosted the National Summits on Indigenous Mental Wellness, bringing together communities, tribal councils, organizations, and leaders to share best practices, build new collaborations, and highlight linkages across sectors.

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
	2.3 (b) Support ongoing regional collaboration and knowledge sharing with mental wellness leads from each FNIHB region, including sharing updates from regional partnership tables. Monthly virtual meetings, annual bilateral meetings, and an annual in-person meeting. (ongoing)			In 2023, in support of a more holistic and social determinants of health approach, the department established a new directorate which brings together responsibility for mental wellness; children, youth and families; and healthy living under the leadership of a dedicated senior executive. Indigenous Services Canada has also created a Health Emergency Management team to support response and recovery activities that include public health emergencies, including outbreaks, social and mental health emergencies, and the health aspects of emergencies cause by natural or accidental hazards.
3. ISC should develop options for overcoming the program delivery challenges created by restrictions on capital spending and revisit and update as required the program's funding approaches, including with respect to the need for sufficient ongoing funding with appropriate escalators, and the appropriate distribution of available funds.	We **do** concur. Indigenous Services Canada will update and refine the funding formulas used to allocate mental wellness resources on an ongoing basis, based on the most relevant and recent data, and will fund knowledge development to inform costing and funding allocations for the mental wellness program. 3.1: Update population-based regional funding allocations with the latest available population data. (Completed, 2024) 3.2: Work with Health Facilities and Infrastructure to map out infrastructure needs and identify	Director General, Mental Wellness and Health Promotion Directorate, FNIHB	Start Date: **01/04/2024** Completion: **3.1. 01/07/2024** **3.2 31/03/2026** **3.3 31/03/2026**	**Status:** ☐ Fully Implemented √ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete Indigenous Services Canada will continue to update population-based regional funding allocations with the latest available population data (Census and/or Indian Registry). In Budget 2021, population-based regional funding allocations were developed using the data from the 2020 Indian registry, and Census 2016. In Budget 2024, these population-based regional funding allocations were updated using data from the 2023 Indian registry, and Census 2021. Indigenous Services Canada will also continue to consider other pertinent statistical information (e.g. hospitalization rates, overdose deaths) when developing regional allocations for specific and targeted initiatives.

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
	options to support community capital needs related to mental wellness. (March 31, 2026) 3.3: Commission a report(s) to assess the funding required to continue to deliver existing mental wellness services and/or to expand or improve mental wellness services with considerations including such issues as capital and infrastructure needs, escalators, distribution of funds, and competitive wages. (March 31, 2026)			Indigenous Services Canada recognizes that demand for mental wellness services continue to grow, along with increasing costs of goods and services, and a highly competitive marketplace for skilled and trained workforce. Indigenous Services Canada uses key partner developed analysis to support funding requests (e.g., Thunderbird Partnership Foundations Wage Parity Report). Securing ongoing mental wellness funding with appropriate growth escalators will continue to be a key priority for Indigenous Services Canada going forward, along with responding to community and partner priorities related to investment in major capital.
4. ISC should work collaboratively with First Nations and Inuit partners to explore opportunities/mechanisms that could further support workforce development and support an updated assessment of the impacts of competitive wages on workforce development and retention.	We **do** concur. Indigenous Services Canada will continue to work with key Indigenous partners to support community-based workforce development, including through providing funding to Indigenous organizations to develop initiatives to support, enhance, and develop the community-based workforce. 4.1: Provide funding for national Indigenous organizations (e.g. Inuit Tapiriit Kanatami, National Centre for Truth and Reconciliation) and Indigenous subject matter experts (e.g. 2 Spirits in Motion, We Matter) to develop resources and training	Director General, Mental Wellness and Health Promotion Directorate, FNIHB	Start Date: **01/04/2021** Completion: **4.1 31/03/2024** **4.2 31/03/2024** **4.3 31/03/2024** **4.4 31/03/2026**	**Status:** ☐ Fully Implemented √ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete Workforce development is a key priority, and Indigenous Services Canada is working with Indigenous organizations to support community-based workers who are the “front lines” of mental wellness service delivery. To note, the department is not the employer of the community-based / treatment centre mental wellness workforce and is limited to its ability to influence wages directly aside from funding the organization which employs these workers. Since 2016, funding for the Mental Wellness Program has increased by over 50%. Investments have enhanced core services and expanded programming and services to new areas of mental wellness. Mental Wellness Funding primarily flows directly to communities and service-delivery organizations, meaning that funding increases can translate directly into increased wages for

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
	materials for the community-based mental wellness workforce (Completed, 2024) 4.2: Provide funding for the development of the First Peoples Wellness Circle's Formative Analysis for the IRS Resolution Health Support Program, which includes recommendations around training needs and networking opportunities for the trauma-specialized workforce. (Completed, 2024) 4.3: Support the First Peoples Wellness Circle and Thunderbird Partnership Foundation to develop a workforce wellness strategy (Completed, 2024) 4.4: Provide funding to support the Thunderbird Partnership Foundation and First Peoples Wellness Circle to explore the development of a national mental wellness workforce association that could consider various priority issues including how to continue to assess the impacts of competitive wages on workforce development and retention.(March 31, 2026)			mental wellness workers, improving organizations and communities' efforts towards worker recruitment and retention. Despite this, short term funding profiles can act as a disincentive to wage increases as organizations weigh long-term financial obligations against shorter term financial commitments. In addition, funding limitations also persist and impede communities' and organizations' ability to match wages offered in the public and private spheres. The department is also continuing to support Indigenous partner efforts to better understand the needs of the community-based workforce, and to make recommendations to ensure workforce sustainability, retention, and support. Since 2022, the mental wellness program has provided funding to Indigenous organizations to support and develop the community-based workforce. Indigenous Services Canada also supported Thunderbird Partnership Foundation to update its work around wage parity, with Thunderbird Partnership Foundation releasing in 2022 Building Sustainable Equity in First Nations Additions Treatment Programs. As the Thunderbird Partnership Foundation recently updated its work on wage parity and given that wage parity will likely be a key concern in the development of the proposed mental wellness workforce association, ISC-FNIHB is addressing the component of this recommendation related to competitive wages by proposing to provide funding for work on workforce development more broadly. This approach recognizes the work that Thunderbird Partnership has already undertaken and supports them to advance priorities without being prescriptive.
5. ISC should work collaboratively with	Indigenous Services Canada will continue to work collaboratively with	Director General, Mental	Start Date: **01/04/2021**	**Status:** ☐ Fully Implemented √ Partially Implemented

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
partners to identify opportunities to align performance measurement activities with community perspectives on wellness, ensure alignment between the logic model and program indictors, and continue to fund partner-led assessments to gather meaningful data (e.g., on important topics, issues, and population-specific considerations within the MWP)	Indigenous partners to develop culturally appropriate and relevant approaches to performance measurement, supporting and leveraging the work of Indigenous partners, and implementing the Mental Wellness Program Results Framework. 5.1: The Mental Wellness Program will provide funding to Indigenous organizations to build capacity and/or implement culturally appropriate and relevant approaches to performance measurement and/or evaluation. (March 31, 2025) 5.2: The Mental Wellness Program will provide a Program Results Framework to the Treasury Board Secretariat, outlining the Mental Wellness Program's proposed approach to performance measurement, key considerations involved in this work, and the preliminary structure of the Results Framework. (Winter/Spring 2024/2025) 5.3: The Mental Wellness Program will implement the Program Results Framework, including the logic model and corresponding performance indicators considerations, developed under the	Wellness and Health Promotion Directorate, FNIHB	Completion: **5.1 31/03/2025** **5.2 31/03/2025** **5.3 31/03/2026**	☐ Implementation did not Commence ☐ Obsolete Indigenous Services Canada has been collaborating closely with Indigenous partners to make changes to the way the mental wellness program measures program effectiveness, and to support Indigenous-led and culturally appropriate approaches to performance measurement and evaluation. The aim of this work is to better align approaches to performance measurement with Indigenous understandings of mental wellness, to support Indigenous leadership in performance management and evaluation, and to reflect the department's commitment to Indigenous data sovereignty. Modernization and reform will be guided by ongoing work with and by Indigenous partners, and the development of the Mental Wellness Program Results Framework. These comprehensive documents will inform and reflect a new way of assessing the impact of the program, structured around understanding the availability, accessibility, quality, and effectiveness of services. Funding announced in Budget 2021 for Métis Mental Wellness also was provided to support ongoing work around Métis mental wellness strategies, data, and indicator work. There was no dedicated Métis mental wellness funding in the evaluation period, but the B2021 funding reflects a broader commitment to supporting Indigenous-led data and indicator work. Indigenous Services Canada continues to work in partnership towards a shift in performance measurement from a focus on outputs to one that supports Indigenous-led measures of health and wellness outcomes. This includes shifting indicators to be reflective of the four themes of: availability; accessibility; quality: and effectiveness.

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
	four key themes of Availability, Accessibility, Quality, and Effectiveness. (March 31, 2026)			

1. Introduction

The overall purpose of the evaluation was to examine the Mental Wellness Program (MWP) activities and funding, as outlined in the Five-Year Evaluation Plan at Indigenous Services Canada (ISC), and in compliance with the Treasury Board (TB) *Policy on Results* and Section 42.1 of the *Financial Administration Act*. The evaluation covered the fiscal years 2015-16 to 2020-21. The total funding allocated to the MWP from 2015-16 to 2020-21 was approximately $2.1 billion.

2. Program Description

2.1 Background

The MWP description has changed over time to recognize the need for a holistic approach to Indigenous mental wellness and to align with Indigenous priorities around mental wellness. The program is guided by key partner led frameworks including the First Nations Mental Wellness Continuum Framework (FNMWCF)[5], Honouring Our Strengths[6], and National Inuit Suicide Prevention Strategy (NISPS)[7]. Each of these frameworks was designed to be comprehensive to mental wellness that is grounded in culture and First Nations- and Inuit-specific determinants of health and well-being.

Health care for First Nations and Inuit is a complex system involving federal, provincial, territorial and First Nations and Inuit jurisdictions. Provinces are responsible for insured health services (i.e., physician and hospital services) to all residents, including Indigenous peoples, but do not generally provide direct health services on reserve. FNIHB funds primary care and public health in some First Nations communities and provides eligible First Nations and Inuit, regardless of where they live, with supplementary health benefits through the Non-Insured Health Benefits Program. Territories deliver insured health services and programs to all their citizens with FNIHB delivering Non-Insured Health Benefits program and providing additional funding for certain programs. First Nations and Inuit organizations and communities are increasingly taking on the direct delivery of federally-funded health services.

FNIHB's Strategic Plan was published in 2012 when FNIHB was part of Health Canada. Its vision is "healthy First Nations and Inuit individuals, families and communities" and its strategic outcome is "(i)n the context of federal health programs under Health Canada, First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs and that improve their health status". It has four strategic goals:

- High quality health services
- Collaborative planning and relationships
- Effective and efficient performance

5 The FNMWCF, launched by the AFN in January 2015, is a national framework that presents a holistic approach and complex model of interconnected elements to support Indigenous organizations and communities in identifying priorities, needs, gaps, challenges and opportunities to improve First Nations mental wellness. The focus of these elements is hope, belonging, meaning and purpose.
6 Honouring Our Strengths is a national framework to address substance use issues among First Nations people by outlining a continuum of care to support strengthened community, regional and national responses to substance use issues.
7 NISPS presents an Inuit-led and Inuit-specific approach to suicide prevention in Inuit Nunangat that is based on social determinants of Inuit health and identifies six priority areas for action that are also relevant for mental wellness more broadly

- Supportive environment in which employees excel

FNIHB endeavors to support First Nations and Inuit in achieving their health and wellness goals, by working with First Nations, Inuit, provinces and territories to advance collaborative models of health and health care that support individuals, families and communities from a holistic perspective, while respecting jurisdictional roles and responsibilities. Its work is guided by several key documents, including a strategic plan, an accountability framework, and partner engagement frameworks. During the evaluation timeframe, FNIHB was transferred from Health Canada to ISC upon the department's establishment in 2017.[8]

Through the MWP, FNIHB provides funding and support for mental wellness programs and services for primarily First Nations and Inuit, which are delivered predominantly on-reserve, and in Inuit Nunangat. In many cases, services and programs are delivered directly by First Nations and Inuit communities and service delivery organizations, along with non-governmental organizations.[9] Corresponding reporting of programming is provided through a range of vehicles such as the community-based reporting template (CBRT)[10], data collection instruments (DCI), and other reporting templates.

The descriptions below encompass the priority areas of the MWP and reflects a more recent picture of the program (i.e., at the end of the evaluation timeframe following changes through the 2020 Mental Wellness Alignment – discussed below).

Health and Cultural Supports

Indian Residential Schools Resolution Health Support Program: This program was initially established as part of the 2006 Indian Residential Schools Settlement Agreement, and provides access to mental health counselling, emotional, and cultural support services to former students of Indian Residential Schools and their families. Services include access to cultural and emotional supports; professional counselling services (individual and family); and assistance with the cost of transportation services (to access counselling services and/or cultural supports).

- Cultural and emotional support workers are hired by community organizations to provide services. Cultural support services are provided by Elders or traditional healers and emotional support services are provided by trained and trauma-informed Indigenous health workers. ISC holds over 135 contribution agreements with organizations across the country to provide these supports.
- Mental health counselling services are provided by regulated service providers such as psychologists and social workers, registered in their province or territory, and enrolled with ISC. Funding for professional mental health counselling services is primarily provided on a 'fee for service' basis (service providers invoice ISC). In cases where professional mental

[8] ISC was created in November 2017, bringing FNIHB (formerly with Health Canada) together with education, essential social services, child and family services programs, lands and economic development, housing, and infrastructure programs from the Department of Indian Affairs and Northern Development.

[9] In the North, some services are delivered by territorial governments with federal funding support from ISC.

10 A data collection tool that is utilized by some communities depending on their funding agreement type (i.e., not in Block funding arrangements)

health counselling is not available locally, ISC provides support for medical transportation, based on Non-Insured Benefits Program policies and guidelines.

Missing and Murdered Indigenous Women and Girls: In June 2018, in response to the Interim Report of the National Inquiry on Missing and Murdered Indigenous Women and Girls, the Government announced funding for health and cultural supports for survivors, family members, and others affected by this issue. These services mirror those offered through the Indian Residential Schools Resolution Health Support Program but are part of the Brighter Futures funding envelope.

Indian Day Schools: In June 2020, the Government announced funding for health supports for former students of historic Federal Indian Day Schools and their family members. Indian Day Schools health and cultural support services mirror those available through the Indian Residential Schools Resolution Health Support Program but are part of the Brighter Futures funding envelope.

Community-based Mental Wellness

Funding is allocated to communities based on priorities and needs established through regional partnership structure and decision-making processes. Outlined below is a description of funding that flows to communities or to organizations providing mental wellness services to communities. This description does not include substance-use related and suicide prevention/life promotion funding, both of which are covered in separate sections. Much of this funding falls under the Mental Wellness Alignment.

Brighter Futures: Brighter Futures was launched in 1992 with the purpose of improving the quality of and access to culturally appropriate, holistic and community-directed mental health, child development, solvent abuse and injury prevention services at the community level. The aim is to help create healthy family and community environments in which community members and children can thrive. First Nations and Inuit communities and territorial governments are eligible to receive funding for this program. Allocation of funding is guided by regional partnership tables and structures.

Building Healthy Communities: Launched in 1994, the Building Healthy Communities program was designed to assist First Nations and Inuit communities and territorial governments in developing community-based approaches to mental health crisis management. Mental health and crisis intervention activities include assessments; counselling services; referrals for treatment and follow-up treatment; and aftercare and rehabilitation to individuals and communities in crisis. Examples of other activities supported by the program include peer support groups; culturally appropriate accredited training on crisis management and intervention; trauma and suicide prevention training for community members and caregivers; and, education and awareness activities that lead to improved mental wellness and suicide prevention. The program also supports community capacity building by training caregivers and community members to deliver mental health-related programs and services. Allocation of funding is guided by regional partnership table and structures.

Victims of Violence: In 2014, the Health Minister committed to $10M annually over ten years to support family violence prevention. The Public Health Agency of Canada (PHAC) administers

$7M to address family violence issues across Canada. FNIHB administers $3M to address First Nations (on-reserve) and Inuit family violence issues through the Non-Insured Health Benefits Program and the MWP. Funding through the MWP largely flows to regions, with approximately $161K to the First Nations Health Authority in British Columbia in the first year and then dividing this amount among National Indigenous Organizations that address family violence in subsequent years (e.g., Native Women's Association of Canada, Pauktuutit).

Mental Wellness Teams: Mental Wellness Teams (MWT) are community-based, client-centred, multi-disciplinary teams that provide a variety of culturally-safe mental wellness services and supports to First Nations and Inuit communities using a wide diversity of service models which may include crisis response, capacity-building, trauma-informed care, land-based care, prevention, early intervention and screening, after care, and care coordination with provincial and territorial services. All MWTs are defined and driven by the community and can include Indigenous traditional, cultural and mainstream clinical approaches to mental wellness services, spanning the continuum of care from prevention to after-care. Each mental wellness team serves a community or cluster of communities and can include a variety of community-based and clinical professionals. The combination of services provided, and composition of the team reflects community needs and priorities. The MWTs are delivered either by First Nations and Inuit communities, tribal councils or organizations with funding provided by contribution agreements with FNIHB. There are currently 71 Teams serving 359 First Nations and Inuit communities.

Suicide Prevention/Life Promotion

National Aboriginal Youth Suicide Prevention Strategy (NAYSPS): Launched in 2005, NAYSPS supports community-based activities to improve mental wellness among Indigenous youth, families, and communities by strengthening protective factors and decreasing risk factors for suicide. The target populations are First Nations youth living on-reserve and Inuit youth living in recognized Inuit communities, ages 10 to 30 years. Eligible recipients include: First Nations and Inuit community health authorities or Band Councils, Tribal Councils, provincial or territorial governments, First Nation or Inuit Land Claimant Organizations, other First Nations or Inuit organizations, and other non-profit organizations supporting First Nations and Inuit communities. This funding is guided by the following principles in that projects should: be evidence-based; use community-based approaches; be community-driven; be culturally-relevant, -appropriate, and -safe; incorporate elements of primary, secondary, and tertiary prevention; meaningfully involve youth; consider varying levels of community readiness; respect local cultures and traditions; promote the prevention of suicide as everyone's responsibility; complement provincial and territorial mandates, and; promote life and well-being . How funding is allocated to recipients differs across regions and is supported by direction from partnership tables and decision-making structures.

Youth Hope Fund (YHF): The YHF is a national level initiative that supports distinctions-based, Indigenous youth-led projects on life promotion. Supported by Budget 2017, this initiative is guided by Indigenous youth and invested $12M over five years with $3.4M per year on-going. First Nations youth and Inuit youth guide approaches to funding through separate decision-making processes. Eligibility, terms and conditions align with those of NAYSPS.

National Inuit Suicide Prevention Strategy (NISPS): NISPS was developed by the ITK and partners to address the high rates of suicide for Inuit living in Inuit Nunangat. Launched in 2016, it was funded via interim measures in 2016 at $9M over three years in response to the need for new funding to support Inuit mental wellness. Budget 2019 committed $50M over 10 years with $5M per year on-going. Funding is allocated directly to ITK and regional Land Claim Organizations.

Substance Use Prevention and Treatment

Specific to problematic substance use, prevention and treatment, ISC currently funds a network of 45 treatment centres (31 adult, 9 youth and 5 family), as well as drug and alcohol prevention services in the majority of Indigenous communities across Canada.

Treatment Centres: Treatment centres provide a range of mainstream and culturally relevant approaches; access to inpatient, outpatient, and day treatment services; services for unique needs (e.g., programming for families, solvent or problematic drug use, and concurrent disorders); and are grounded in traditional culture. These centres are operated by First Nations and Inuit organizations and/or communities.

Community-based: The community-based component provides prevention, intervention, aftercare and follow-up services in First Nations and Inuit communities across Canada. In most communities, this component is delivered by community-based workers who are responsible for identifying community needs and delivering program activities. This can include cultural activities including on-the-land, education and awareness activities, youth-specific activities, providing training and education to front line workers, providing appropriate assessment of clients and referral of clients to other services including substance use treatment, and providing community level aftercare services to clients returning from residential treatment.

Other funded components include:

Opioids-specific programming: To respond to public health challenges presented by the ongoing opioid crisis, funding has also been provided to support opioid agonist therapy sites that offer comprehensive wraparound services in areas of high need. Wraparound sites support access to community-based psychosocial services and supports for the treatment of addictions (e.g., wrap-around care). Psychosocial services are community-specific, and can include conventional interdisciplinary treatment (e.g., group, individual, and/or family therapy with trained mental health workers and counsellors/tele-counselling, life skills development, ‘aftercare’, etc.), and community-based services and supports grounded in culture (such as land-based healing, ‘wraparound’ care, healing centers, elder referral, resiliency building interventions, etc.). Minimal, moderate, or comprehensive psychosocial services and supports for the treatment of substance use are offered either on-reserve or within 1 hour of ground/water travel. The program has also undertaken the coordination of bulk purchases of naloxone and nasal spray naloxone and increasing access to take-home naloxone kits and training in their use.

Quality Improvement: Through ongoing funding secured under the Canadian Drugs and Substances Strategy (CDSS), ISC-FNIHB supports a number of quality improvement activities.

- **Certification:** The issue of attracting and retaining skilled workers in the substance use field is recognized as an ongoing challenge for treatment centres and communities. ISC-FNIHB provides communities and treatment centres with additional funding to attract and retain these workers through financial incentives and enhanced training opportunities, both tied to the certification of substance use treatment counsellors and community-based workers.
- **Accreditation:** ISC-FNIHB also provides funding to support treatment centres to attain and retain accreditation. Accreditation is a process that treatment centres use to assess and to improve the quality of their services. This includes examining everyday activities and services against national standards of excellence. Accreditation provides valuable measures to use within and among organizations to reinforce organizational strengths and build important linkages within community and between community and other health services. Centres have implemented many best practices within their programs as a result of accreditation. Through ISC-FNIHB funding support, 85% of centres (2017-18 reporting) are accredited or are in the process of becoming accredited.
- **Modernization:** Funding is provided to treatment centres to support modernization and reorientation of services to strengthen and expand services to better meet client needs.

Alongside delivering funding for the provision of services, core activities of the MWP include:

- Collaborating with Partners
- Developing Program Policy
- Sharing Knowledge
- Building Capacity
- Supporting Self-Determination

Mental Wellness Program Alignment

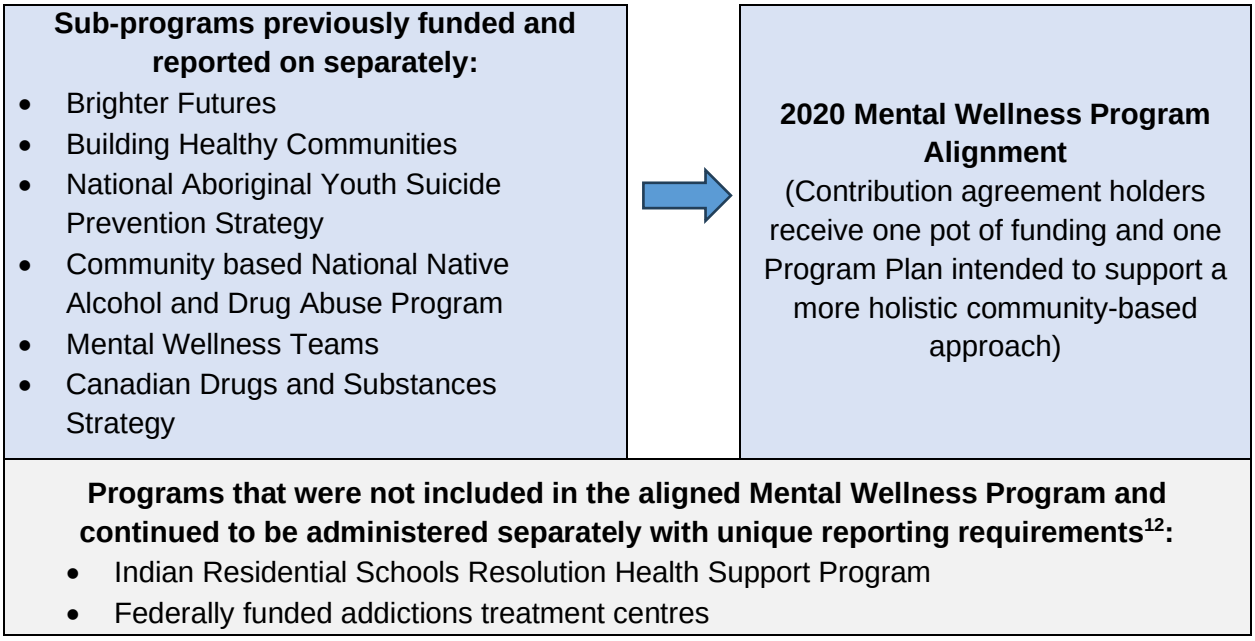
Changes have been made to the MWP to respond to an identified need for a more holistic approach to mental wellness (e.g., as concluded from the 2016 Evaluation of the First Nations and Inuit Mental Wellness Programs and regional needs assessments) and to align with the priorities articulated in key partner frameworks. Prior to the 2020 Mental Wellness Alignment, recipients received separate funding for each funding stream they administered, implemented in-line with the required objectives and activities of their corresponding FNIHB-MWP program plans, and submitted separate reporting (e.g., through the Community-Based Reporting Template).

Through the Alignment, several community-based programs were aligned (i.e., collapsed) into a single pot of funding. This was intended to reduce siloes and support greater flexibility for recipients to plan programs according to unique community needs, regardless of their type of funding agreement.[11] A revised Mental Wellness Program Plan and reporting guide was also subsequently developed to replace the existing plans of the previously independent funding streams (i.e., presenting one overarching program plan in-line with the continuum framework). As Mental Wellness Alignment occurred near the end of the evaluation timeframe, preliminary/early

[11] While recipients in more flexible agreements, such as Flexible and Block funding, were already able to reallocate fundings within a block of programs, those in less flexible agreements (e.g., Set and Fixed Funding) did not have provisions for reallocating funds.

perceptions of its impacts were explored with key informants familiar with the Alignment; however, more engagement with communities through Phase 2 and beyond will provide more information on the impact of alignment. The figure below presents the funding streams that were collapsed through the Mental Wellness Alignment as well as funding streams that continued to be administered separately (i.e., not all programs within the MWP were aligned).

Figure 1. MWP Program Alignment



Accordingly, recipient reporting for funding related to those sub-programs included in Mental Wellness Alignment, was streamlined with the introduction of a new overarching "Mental Wellness Program" data collection instrument, although separate instruments continued to be used for programs that remain separate (e.g., Indian Residential Schools (IRS) Resolution Health Support Program and federally funded Substance Use Treatment Centres).

Program Resources

Funding for the Mental Wellness Program increased during the evaluation timeframe from an approximate annual allocation of $236M in 2015-2016 to $481M in 2021-22.[13] The table below presents MW Program expenditures by functional area. In 2020-2021, several functional areas were collapsed under the Mental Wellness Program Alignment, as indicated by grey-shaded boxes.

[12] Funding for health and cultural supports related to Missing and Murdered Indigenous Women and Girls and Indian Day Schools flow under Brighter Futures, but are administered separately and have a unique DCI.
[13] A depiction of funding allocations by stream/program area was not available as part of the evaluation data.

Table 2. MWP Expenditures by Functional Area Between 2015-16 and 2020-21

MW Program Expenditures						
Functional Area	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Policy Development & Program Oversight	$7,395,056.85	$10,106,439.20	$10,949,152.50	$10,576,839.60	$10,456,593.06	$19,658,780.64
Building Healthy Communities *Captured under "Mental Wellness Program" as of 2020/21*	$41,534,980.33	$43,033,692.78	$46,261,203.15	$48,718,897.78	$44,506,687.47	
Brighter Futures *Captured under "Mental Wellness Program" as of 2020/21*	$55,937,871.72	$55,412,653.76	$56,299,730.05	$68,454,602.67	$64,457,177.41	
Suicide Prevention *Captured under "Mental Wellness Program" as of 2020/21*	$9,706,703.25	$10,882,735.69	$10,847,403.50	$14,336,014.87	$18,293,824.87	
Mental Wellness Teams *Prior to 2016-17, MWT did not have their own functional area code and expenditures were coded as part of the CDSS. Captured under "Mental Wellness Program" as of 2020/21*		$9,395,970.83	$18,344,422.14	$21,572,894.13	$20,955,591.44	
Hope for Wellness Line		$87,543.00	$587,310.53	$358,275.37	$2,087,428.48	2,584,136.40
NNADAP – Drug Abuse *Captured under "Mental Wellness Program" as of 2020/21*	$47,743,116.22	$50,634,136.98	$51,823,438.04	$55,407,177.22	$56,700,475.44	
NNADAP – Treatment Centres	$32,264,488.48	$34,207,807.60	$34,798,594.06	$44,944,035.08	$51,226,494.40	$46,059,656.72
NYSAP - Youth Solvent Abuse Program	$18,785,597.00	$19,890,724.87	$20,878,259.93	$22,427,257.09	$20,619,037.21	$15,420,498.37
Canadian Drugs and Substances Strategy *Prior to 2016-17, MWT expenditures would have been captured under CDSS. Captured under "Mental Wellness Program" as of 2020/21*	$13,641,689.38	$12,755,872.85	$13,412,302.42	$17,677,878.69	$13,677,936.90	
IRS RHSP *Includes both community-based program expenditures (Gs and Cs) as well as Mental Health counselling and medical transportation expenditures (O&M)*	$57,060,053.70	$64,621,567.43	$69,074,196.75	$72,462,676.24	$79,655,596.39	$68,969,370.45
Mental Wellness Program* **					$445,783.07	$338,247,087.40
Total	**$284,069,556.93**	**$311,029,144.99**	**$333,276,013.07**	**$376,936,548.74**	**$383,082,626.14**	**$490,939,529.98**

****Includes: MMIWG IO, Indian Day Schools IO, MWT IO, Mental Health Crisis Intervention Teams IO, CDSS IO, Harm Reduction IO*

Most of this increase was owing to new investments, though some mental wellness funding streams do include a 3% escalator that contributed to growth. Regarding the longevity of funding, an estimated $437.9M per year (48% of total new investments announced) was time limited.[14] These additional investments were received to meet the immediate mental wellness needs of communities by supporting Indigenous-led suicide prevention, life promotion, and crisis response, including through crisis line intervention services, and enhancing the delivery of culturally appropriate substance use treatment and prevention services in Indigenous communities. They also included funding for mental health, cultural, and emotional support to Survivors and Intergenerational Survivors of Indian Residential Schools and Federal Indian Day Schools as well as those affected by the tragedy of Missing and Murdered Indigenous Women and Girls.

Resource Allocation

Generally, Mental Wellness funding is not proposal based, but is allocated and provided to communities, treatment centres, and regional and national Indigenous organizations in several ways. Over the years, new funding was allocated from FNIHB headquarters to regions based on the Modified Berger Formula, needs-based allocations, and/or through distributing base funding for all regions. Where the funding was ongoing, it remained fixed at those established levels. Regions subsequently distribute their allocations to recipients, where decisions related to community-based funding often occur through regional partnership structures.

2.2 Program Objectives and Expected Outcomes

The MWP acts as a funder that supports access to mental wellness services primarily for First Nations on-reserve and Inuit in Inuit communities[15], including funding communities and/or service delivery organizations in developing and delivering programs and services to realize intended outcomes. The primary overall objective of the MWP is to support Inuit and First Nations in achieving and maintaining improved mental wellness.

As indicated in the program logic model in Appendix B, the intended short-, medium-, and long-term outcomes of the MWP are as follows[16]:

Short-term/Immediate intended outcomes:

- Indigenous communities and organizations deliver mental wellness services
- Indigenous people and communities have access to mental wellness services

Medium-term/intermediate intended outcomes:

- Indigenous people receive social services that respond to community needs

[14] This was calculated based on a sum of the enhancements described in Appendix A which had a defined range (i.e., $Xx funding over Yy years)

[15] The Trauma-Informed Health and Cultural Support Programs provide services to eligible individuals regardless of Indigenous status or place of residence within Canada.

[16] While the logic model presents the intended outcomes at the time of the evaluation, the logic model and intended outcomes are continuously evolving to reflect changing needs and priorities as they relate to mental wellness.

Long-term/ultimate intended outcome:

- Indigenous communities are healthier

2.3 Program Management and Key Partners

Program Management

The MWP is coordinated and supported by FNIHB staff within both the national and regional offices. FNIHB-MWP staff at the National Office lead strategic policy development and planning in support of the MWP, collaborating with FNIHB regional offices and First Nations and Inuit partners. The core responsibilities of National Office include but are not limited to:

- Strategic policy, including budget proposals and Treasury Board submissions
- Funding allocations for new investments
- National program monitoring, data collection and analysis, supporting audit and evaluation
- Working with regional FNIHB MWP staff to support program delivery, cross-regional sharing, and policy development
- Collaboration with national First Nations and Inuit organizations.
- Supporting linkages with Other Government Departments as relevant
- Coordinating national initiatives, funding and contribution agreements (e.g., Youth Hope Fund)

Regional offices are located within the Atlantic, Northern, Quebec, Ontario, Manitoba, Saskatchewan, and Alberta Regions. In British Columbia, as part of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance,* the Government of Canada transferred its role in the design, management, and delivery of First Nations health programming to the First Nations Health Authority.

The FNIHB regional offices play a lead role in supporting communities and service delivery organizations with program delivery by working with First Nations and Inuit partnership tables and structures. The regional offices are also responsible for the management of funding arrangements, program performance monitoring, and information roll-ups. Given the diversity of contexts, regions have diverse operations and models in-line with unique priorities and realities. They also have unique regional partnership structures that support decisions around investments and programming.

Program Partners

FNIHB works with key partners at the national and regional levels to inform program and policy development and support service delivery. National Indigenous partners help to shape, guide, and advance the First Nations and Inuit health policy agendas as well as develop tools and resources to guide communities and service delivery organizations, and regional partners play a critical role in service design and delivery. Additional details about key FNIHB partnerships include:

- **National Indigenous Partners:** Key national partners include the Assembly of First Nations (AFN) and Inuit Tapiriit Kanatami (ITK), both of whom are members on FNIHB's Senior Management Committee on Policy and Planning, as well as the Thunderbird Partnership Foundation, First Peoples Wellness Circle, and We Matter. Other partner organizations support the delivery of national level initiatives as relevant. Collaboration with partner organizations is key to identifying priorities, gaps, challenges, and opportunities that are essential to policy and programming.

- **Regional Partnerships:** Funding is allocated to communities and/or service delivery organizations based on priorities and needs guided by regional partnership structures, including in some cases, formal regional partnership tables and decision-making processes. Differing models exist across regions, with some regions having formal decision-making tables and processes directed by Indigenous partners to identify priorities and emerging issues. As examples, the Alberta region involves the Alberta Health Co-Management Table; the Northern region involves several bi/tri-lateral partnership mechanisms; the Quebec region includes the Permanent Partners Committee; and the Atlantic region includes the Atlantic First Nations Health Partnership Table and the Labrador Inuit Tripartite Health Committee.

3. Evaluation Methodology

3.1 Indigenous Engagement

The evaluation team collaborated with an Evaluation Advisory Group (EAG) to support the design and conduct of the evaluation. The EAG was chaired by the Director of Evaluation and included representation from the AFN, ITK, Thunderbird Partnership Foundation, and the First Peoples Wellness Circle, alongside MWP representatives at the national and regional level, ISC Evaluation, and a third-party consultant. The aim of the EAG was to gather input at key stages of the evaluation, including development of the methodology, data collection and sampling plan, preliminary findings, and draft and final reports.

3.2 Scope and Evaluation Issues

In line with the Treasury Board *Policy on Results*, the objective of the evaluation was to assess the relevance as well as the performance in terms of effectiveness, design, delivery, and efficiency of MWP funding and support for First Nations and Inuit. The evaluation also covers thematic areas and priority issues relevant to the program, partners, and to the broader department, including service transfer, the COVID-19 pandemic, climate change, children, youth, and families, and impacts through a gender-based analysis plus (GBA plus) lens.

The evaluation reviewed the period from Fiscal Year 2015-16 to 2020-21.[17] Findings are intended to provide reliable evidence to inform policy and program improvement based on identified wise practices, opportunities, and lessons learned in First Nations and Inuit contexts. All FNIHB regions were included in the evaluation, except for British Columbia due to transfer of First Nations health programming to the First Nations Health Authority.

Phased Evaluation Approach

Given the importance of both the program and the subject of mental wellness for Indigenous communities, the EAG highlighted the need for an Indigenous-guided approach to the evaluation that focused on community voices; however, it was recognized that such an approach would be a challenge given that limited time remained to complete the evaluation within the five-year window prescribed by the *Financial Administration Act*.

As such, the EAG proposed that a phased approach would focus on different aspects of the MWP, meet required timelines, and allow for time to meaningfully engage with First Nations and Inuit partners and communities. Therefore, the content within this report reflects findings from the initial phase and does not include all relevant evidence, including information from community-based leadership, staff and clients of the MWP. The first recommendation of this report, however, is to support an Indigenous partner-led second phase of study that focuses on evidence from First Nations and Inuit communities that was not captured within Phase One. Discussions are already underway to advance planning and design for the second phase of the study.

[17] Due to the COVID-19 pandemic, the evaluation experienced considerable delay in its start date.

Based on guidance from the EAG, the initial phase of the evaluation focused on the governance-level, with representation limited to national and regional-level perspectives (e.g., national partner organizations, regional representatives overseeing funding, coordination, and/or management of services, and a small number of treatment centre representatives) as well as the perspectives of MWP staff. The evaluation questions used to guide the initial phase of the evaluation are provided in Appendix C.

3.3 Evaluation Design and Methods

The evaluation was conducted by the ISC Evaluation Branch in collaboration with an external consultant. It utilized a mixed-methods approach that gathered data through a literature review, document and data review, and key informant interviews. Additional detail about the evaluation methodology (i.e., data sources, analytical approach) can be found in Appendix D.

Literature Review

The evaluation team reviewed existing literature to assess select issues/questions of interest, including key needs, priorities, and gaps as they relate to Inuit and First Nations mental wellness; health governance and service transformation; the COVID-19 pandemic; and perspectives on climate change. The review included both peer-reviewed (scientific and academic) and grey literature (relevant media articles and websites) from a variety of sources (e.g., National Collaborating Centre for Indigenous Health, relevant publications, resources from Indigenous and community-based groups).

Document and Data Review

Program documents and data were reviewed to support understanding of program context (e.g., foundational documents, frameworks, key changes), governance, key activities, as well as what has been accomplished to date with respect to objectives and goals. The document review also leveraged resources developed by First Nations and Inuit organizational partners, such as sub-program evaluations, needs assessments, advocacy documents, and other research reports. Furthermore, the evaluation reviewed data collected and held by ISC, including financial data (i.e., total budget allocation and expenditure) and performance measurement data.

Key Informant Interviews

Interviews were conducted with representatives of national and regional First Nations and Inuit organizations, as well as with FNIHB staff at the national and regional levels. FNIHB-MWP staff were identified by National Office staff; First Nations and Inuit representatives were identified by the EAG and through a snowball sampling approach (e.g., suggestions provided by regional FNIHB staff who were interviewed). Efforts were made to ensure regional representatives (i.e., all regions with the exception of British Columbia) and to engage Inuit and First Nations partners representing a diversity of contexts (e.g., urban, remote and isolated). The objective of the interviews was to gather in-depth information from a variety of perspectives on various issues related to the MWP. The interviews were semi-structured to provide participants with greater opportunity to share lessons, experiences, views, and observations that they believed to be

relevant to the MWP and the broader topic of mental wellness. The table below provides a breakdown of respondents by sub-group.

Table 1. Key Informant Interview Response Breakdown by Sub-Group

Sub-Group	Contributors (n)
Representatives of National First Nations Organizations	6
Representatives of Regional First Nations Organizations	5
Treatment Centre Representatives	3
Representatives of National Inuit Organizations	3
Representatives of Regional Inuit Organizations	5
FNIHB National Staff	6
FNIHB Regional Staff (all regions represented except for BC)	20
Total	**48**

The table below presents the reporting technique based on the frequency of responses.

Table 2. Response frequency reporting technique

Response Summary	% of Responses
All	100%
Almost All	80-99%
Most	60-79%
Approximately Half	40-59%
Some	20-39%
A Few	<20%

3.4 Limitations

The table below describes the limitations encountered during the evaluation and the corresponding mitigation strategies utilized by the evaluation team to support data quality and the development of reliable findings.

Table 3. Limitations and Mitigation Strategies

Limitation	Mitigation Strategy
Retrospective focus of the evaluation. Evaluation contributors were asked to provide retrospective feedback on the MWP (2015-16 to 2020-21). There is a risk that contributors inadvertently spoke to the present-day context and/or were only familiar with more recent program context due to staff changeover.	To mitigate this risk, all prospective interviewees were advised of the timeframe prior to agreeing to an interview. At the time of the interview, participants were again reminded of the timeframe.

Limitation	Mitigation Strategy
Potential for bias due to limited Inuit and First Nations representation. Beyond the decision to reserve community level engagement to a second phase of study, the current evaluation had relatively limited representation of First Nations and Inuit representatives, particularly at the regional and sub-program level (e.g., treatment centres, IRS RHSP, Mental Wellness Teams, etc.), due to a combination of reasons (i.e., condensed timeframe, limited capacity, and staff changeover since 2020-21). Therefore, findings that emerged from this study (phase one) cannot be generalized to represent all contexts or voices in the mental wellness space.	Efforts to mitigate this challenge included frequent follow-up, attending events/meetings to raise awareness about the evaluation, offering flexible formats for participation (e.g., condensed interview/phone call, responses in writing), and extending the evaluation timeframe to allow for additional contributors.
The large scope of the evaluation limited a comprehensive assessment of all questions, sub-questions, and indicators. This study (phase one) was guided by 14 overall questions designed by the ISC Evaluation Branch, several of which had corresponding sub-questions and detailed indicators. While efforts were made to capture all priority issues in all discussions, the semi-structured nature of the interviews, coupled with limited availability of some key informants, and gaps in some program documentation constrained the assessment of all topics, questions, and sub-questions.	To mitigate this challenge, the interview guides were revisited to ensure priority questions and topics were covered in the interviews. Furthermore, interview conversations with some representatives (FNIHB staff) were scheduled for 90 minutes to maximize input. Given the mixed-method approach and phased design of the evaluation, it is also expected that gaps in knowledge could be explored and captured through other lines of evidence such as through a follow-up study (a phase two).

3.5 Organization of Findings

The section below presents the key findings that emerged from the initial evaluation, organized by evaluation issue. To reduce redundancy and support reporting narrative, some evaluation questions have been integrated/consolidated to focus on an overall issue/theme.

4. Program Relevance

4.1 Need for the Program

Finding 1: There is a great need for funding and support through the MWP to address the ongoing and intergenerational impacts of colonization and systemic racism and to support healing and well-being across the lifespan.

All lines of evidence highlight that **funding through the MWP was crucial to supporting First Nations and Inuit to deliver mental wellness programs that respond to their unique priorities**. While there were important differences in the realities, needs, and perspectives within and across First Nations and Inuit related to mental wellness, common threads were identified with respect to growing demands placed on services (discussed below and to be further explored in Phase Two).

Healing from Intergenerational Trauma and Settler Colonial Legacies

All key informants and program reports indicate that **there was a continued need for funding to support the healing needs of Survivors, their families, and communities**, and almost all agreed that **program funding had not kept pace against growing pressure on services**.[18] The rupture of Indigenous identities, families, and communities as a result of Indian Residential Schools, Federal Indian Day Schools, the Sixties Scoop, and colonial policies that continue to displace children from the care of families and communities has had rippling and multigenerational impacts.[19] Namely, the impacts of these measures have disrupted many protective factors for good health and well-being, including cultural identity and practices, languages, traditional knowledge systems, relationships, and access to the land.[20,21] According to a report by the First Nations Information Governance Centre (FNIGC), many Survivors that participated in the Indian Residential Schools Settlement Agreement experienced re-traumatization and re-victimization, as some were required to recall painful memories of abuse, while others had not previously spoken about their experiences,[22] and families may have learned about their stories for the first time.[23] Media articles indicate that these impacts are echoed by Federal Indian Day School and Sixties Scoop Survivors, who also face daunting processes associated with establishing their claims.[24] For many communities and families, the FNIGC report noted that a "culture of silence"

[18] A few representatives perceived funding to be sufficient, though given the retrospective nature of the evaluation, it was not clear if funding levels were considered within the timeframe of 2015-2021 or present-day context, when funding levels approximately doubled.
[19] Allan & Smylie. (2015). "First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada." https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf

[20] Gray, A. P., Richer, F., & Harper, S. (2016). "Individual-and community-level determinants of Inuit youth mental wellness." *Canadian journal of public health*, *107*, e251-e257.

[21] Health Canada & Assembly of First Nations. (2014). "First Nations Mental Wellness Continuum Framework – Summary Report." https://www.sac-isc.gc.ca/eng/1576093687903/1576093725971

[22] National Centre for Truth and Reconciliation. (2020). "Lessons Learned: Survivor Perspectives." https://nctr.ca/wp-content/uploads/2021/01/Lessons_learned_report_final_2020.pdf

[23] First Nations Information Governance Centre. (2017). "Assessing the current needs for continued healing among Indigenous peoples in Canada: Responding to the legacy of the Indian Residential School system and the Truth and Reconciliation Commission Calls to Action."

[24] Meloney, N. (2020). "Day school claimants say lessons about trauma should have been learned from residential schools settlement." CBC News. https://www.cbc.ca/news/indigenous/indian-residential-day-schools-survivors-lessons-learned-1.5471425

surrounding residential schools and other experiences of abuse have prevented Survivors from publicly discussing their stories and beginning their healing journey until recently.[25] Most key informants and research reports stated that these existing needs for healing are further intensified by families processing grief and loss over the on-going tragedy of missing and murdered Indigenous women and girls[26], societal events that may activate past trauma, and the COVID-19 pandemic, which have led to tremendous grief, re-traumatization, and an inundation of calls for mental wellness support.[27]

Further to this, **the aforementioned FNIGC research report stated that Survivors, families, and communities have noted a "chronic lack of healing and wellness resources,"** as supports such as the Aboriginal Healing Foundation[28] were shut down, and continued funding for the Indian Residential Schools Resolution Health Support Program (IRS RHSP) remained uncertain and insufficient.[29] A qualitative assessment conducted by First Peoples Wellness Circle also stated that Indigenous peoples have reported that parallel services provided by external service organizations (e.g., counselling) were failing to meet their needs and in some cases have led to further harm, as services often lacked cultural safety and an understanding of working with Indigenous Survivors.[30] For Inuit and First Nations communities in remote and northern areas, the National Inquiry Final Report noted that access to continuous and appropriate support is further hindered by the transient nature of much of the workforce, including counsellors and other support workers that were present in a community only for limited periods of time, creating challenges for building safe and trusting relationships for healing.[31]

Overall, the document review and primary evidence indicated that the interlocking effects of limited resourcing of services, intergenerational trauma, racism, and continued inequities in the social determinants of health have greatly impacted some communities and populations. This was

[25] First Nations Information Governance Centre. (2017). "Assessing the current needs for continued healing among Indigenous peoples in Canada: Responding to the legacy of the Indian Residential School system and the Truth and Reconciliation Commission Calls to Action."

[26] First Peoples Wellness Circle. (2021). "Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories." https://fpwc.ca/wp-content/uploads/2023/02/FPWC_QA_Report_Formatted_Digital.pdf

[27] First Peoples Wellness Circle. (2021). "Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories." https://fpwc.ca/wp-content/uploads/2023/02/FPWC_QA_Report_Formatted_Digital.pdf

[28] In 2014, the Aboriginal Healing Foundation, an Indigenous-run organization providing funding for community-based healing programs, was closed.

[29] First Nations Information Governance Centre. (2017). "Assessing the current needs for continued healing among Indigenous peoples in Canada: Responding to the legacy of the Indian Residential School system and the Truth and Reconciliation Commission Calls to Action."

[30] First Peoples Wellness Circle. (2021). "Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories." https://fpwc.ca/wp-content/uploads/2023/02/FPWC_QA_Report_Formatted_Digital.pdf

[31] National Inquiry. (2019). Reclaiming Power and Place: Final Report Volume 1a." https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a.pdf

further exemplified by declarations of crises and calls for action to address alarming statistics including rates of suicide during the evaluation timeframe.[32,33,34,35]

Substance Use Supports

Most key informants indicated that **addressing the disproportionate harms from substance use experienced by Indigenous peoples as a result of colonial traumas remained an ongoing priority for many First Nations and Inuit communities**. This perspective is echoed in the broader literature. For example, a 2019 policy brief on substance use among Indigenous peoples highlighted the connection in its title: "Indigenous harm reduction = reducing the harms of colonialism."[36] Similarly, an article by Dr. Marcia Anderson described how the imbalance of stressors (racism, intergenerational trauma, poverty, childhood apprehension) compared to buffers (strong cultural identity, connection to family, community, and culture, participation in traditional activities) adversely impacts both physical and mental health, which is seen through statistics such as substance use.[37]

In many regions of Canada, Indigenous people have been disproportionately impacted by the opioid crisis.[38] In Alberta, for instance, First Nations people represent approximately 6% of the population, yet they represented 22% of all opioid poisoning deaths in 2020 – an increase from 14% in 2016.[39] Similar reports of the disproportionate harms for First Nations peoples have also been documented in other regions such as in Ontario[40] and Saskatchewan.[41] Furthermore, the 2019 AFN Opioid Strategy report noted that the challenge of opioid use has been increasingly complicated by the toxic illegal drug supply (e.g., fentanyl and carfentanil), resulting in the declaration of public health emergencies due to rising overdoses in a number of First Nations communities.[42] In addition to the opioid crisis, some communities have also reported

[32] It is important to acknowledge that, until recently, suicide and other mental health emergencies were a relatively rare occurrence in First Nations and Inuit communities, and there is considerable variation in mental health outcomes as not all communities are disproportionately impacted.

[33] ITK. (2016). "National Inuit Suicide Prevention Strategy." https://www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf

[34] Mihychuk, M. (2017). "Breaking point: the suicide crisis in Indigenous communities." https://www.ourcommons.ca/Content/Committee/421/INAN/Reports/RP8977643/inanrp09/inanrp09-e.pdf

[35] Statistics Canada (2019). "Suicide among First Nations people, Métis and Inuit (2011-2016): Findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC)," https://www150.statcan.gc.ca/n1/daily-quotidien/190628/dq190628c-eng.htm

[36] Interagency Coalition on AIDS and Development & Canadian Aboriginal AIDS Network. (2019). "Policy Brief: Indigenous harm reduction = reducing the harms of colonialism." https://caan.ca/wp-content/uploads/2021/05/Indigenous-Harm-Reduction-Policy-Brief.pdf

[37] Anderson, M. (2018). "Crystal meth is a colonial crisis and its root causes must be addressed." https://www.cbc.ca/news/canada/manitoba/crystal-meth-colonial-crisis-opinion-1.4639133

[38] Hatt, L. (2021). "The Opioid Crisis in Canada." *Library of Parliament.* https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/202123E#txt59

[39] FNIGC & Alberta Health. (2021). "Opioid response surveillance report: First Nations people in Alberta." https://open.alberta.ca/dataset/ef2d3579-499d-4fac-8cc5-94da088e3b73/resource/8f1214fc-4db2-4e73-a297-1303293c4e90/download/health-alberta-opioid-response-surveillance-report-first-nations-people-2021-12.pdf

[40] Chiefs of Ontario. (2021). "Chiefs of Ontario Calls for Action for Address Rise of Opioid-Related Deaths among First Nations in Ontario." https://chiefs-of-ontario.org/chiefs-of-ontario-calls-for-action-to-address-rise-of-opioid-related-deaths-among-first-nations-in-ontario/#:~:text=In%20the%20first%20year%20of,the%20rest%20of%20the%20population.

[41] Sanders, L. (2021). "First Nations leaders in Saskatchewan grappling with opioid crisis." *APTN News.* https://www.aptnnews.ca/national-news/first-nations-leaders-in-saskatchewan-grappling-with-opioid-crisis/#:~:text=It%20notes%20that%20116%20First,the%20population%20in%20the%20province.

[42] AFN. (2019). "AFN Opioid Strategy."

simultaneous crises due to the rise in methamphetamine use and impacts on community health and safety.[43,44] To illustrate, data from Saskatchewan and other prairie provinces indicated that Indigenous peoples have been disproportionately harmed by methamphetamine – since 2016, 55% of drug-caused deaths involving methamphetamine in Saskatchewan were among First Nations, Inuit, and Métis peoples.[45]

There is limited data related to substance use experiences among Inuit, Two-Spirit, gender non-binary, and gender diverse people.[46] A report from the Canadian Centre on Substance Use and Addiction and ITK suggested that rates of heavy episodic drinking are higher among some Inuit,[47] and several key informants indicated that the availability and normalcy of substance use has increased in some regions. Through a Standing Committee report, **Inuit youth have also described a growing need for substance use treatment facilities across the regions alongside other health infrastructure.[48]** Among Two-Spirit and gender minoritized Indigenous peoples, some studies point to increased harm related to substance use and significant barriers to accessing affirming and culturally safe services and care; however, there are considerable gaps in data collected.[49,50]

First Nations- and Inuit-Defined Models to Supporting Mental Wellness

First Nations and Inuit partners have consistently highlighted the following factors as important to effectively responding to priorities in mental wellness,[51,52,53] and many of which are present within the MWP (e.g., focus on flexible funding and community-determined programming; See: 4.2).

[43] Anderson, M. (2018). "Crystal meth is a colonial crisis and its root causes must be addressed." https://www.cbc.ca/news/canada/manitoba/crystal-meth-colonial-crisis-opinion-1.4639133

[44] Casey, B. (2019). "Impacts of Methamphetamine Abuse in Canada." https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10533589/hesarp26/hesarp26-e.pdf

[45] Samson, S. (2022). "Surge in prairie meth use forces First Nations to find creative solutions." https://www.cbc.ca/news/canada/saskatchewan/crystal-meth-first-nations-prairies-solutions-programs-addictions-1.6613933

[46] Interagency Coalition on AIDS and Development & Canadian Aboriginal AIDS Network. (2019). "Policy Brief: Indigenous harm reduction = reducing the harms of colonialism." https://caan.ca/wp-content/uploads/2021/05/Indigenous-Harm-Reduction-Policy-Brief.pdf

[47] CCSA & ITK. (2021). "Substance Use, Mental Health and Suicide among Inuit in Canada." https://www.ccsa.ca/sites/default/files/2021-10/CCSA-Substance-Use-Mental-Health-Suicide-among-Inuit-Report-Summary-2021-en_2.pdf

[48] Mihychuk, M. (2017). "Breaking point: the suicide crisis in Indigenous communities." https://www.ourcommons.ca/Content/Committee/421/INAN/Reports/RP8977643/inanrp09/inanrp09-e.pdf

[49] Interagency Coalition on AIDS and Development & Canadian Aboriginal AIDS Network. (2019). "Policy Brief: Indigenous harm reduction = reducing the harms of colonialism." https://caan.ca/wp-content/uploads/2021/05/Indigenous-Harm-Reduction-Policy-Brief.pdf

[50] National Collaborating Centre for Aboriginal Health. (2016). "An introduction to the health of Two-Spirit people: historical, contemporary, and emergent issues." https://www.ccnsa-nccah.ca/docs/emerging/RPT-HealthTwoSpirit-Hunt-EN.pdf

[51] ITK. (2016). "National Inuit Suicide Prevention Strategy." https://www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf

[52] Health Canada & Assembly of First Nations. (2014). "First Nations Mental Wellness Continuum Framework – Summary Report." https://www.sac-isc.gc.ca/eng/1576093687903/1576093725971

[53] Mihychuk, M. (2017). "Breaking point: the suicide crisis in Indigenous communities." https://www.ourcommons.ca/Content/Committee/421/INAN/Reports/RP8977643/inanrp09/inanrp09-e.pdf

To illustrate, the FNMWCF advances a model for mental wellness services that is rooted in culture and comprised of multiple layers and key elements (notably: culture as the foundation of wellness, community development, quality care systems, partnership and collaboration, and enhanced flexible funding). Hope, belonging, meaning, and purpose are at the centre of the model: the interconnected elements that lead to optimal mental wellness.[54]

Similarly, the National Inuit Suicide Prevention Strategy advances an Inuit-led approach to address and prevent high rates of suicide in Inuit Nunangat. Six holistic, priority areas are identified to reduce risk factors and promote protective factors. This includes creating social equity and addressing Inuit-specific determinants of health (1), creating cultural continuity through grounding approaches in language, culture, and history (2), nurturing healthy Inuit children (3), ensuring access to a full continuum of mental wellness services (4), healing and addressing unresolved trauma and grief from colonization (5), and mobilizing Inuit knowledge and promising practices (6).[55]

4.2 Alignment with Priorities of First Nations and of Inuit

Finding 2: Funding through the MWP is mostly relevant to the priorities of First Nations and Inuit because of its flexibility and recent funding enhancements in key areas. However, some considerations related to funding stipulations (e.g., capital spending) and need for services for priority populations were noted.

Efforts to Align the MWP

The MWP undertook various partnership and engagement activities during the evaluation timeframe to understand the priorities of First Nations and Inuit related to mental wellness services. Nationally, MWP staff reported regularly collaborating with national partner organizations (including through the First Nations Mental Wellness Continuum Framework

[54] Health Canada & Assembly of First Nations. (2014). "First Nations Mental Wellness Continuum Framework – Summary Report." https://www.sac-isc.gc.ca/eng/1576093687903/1576093725971

[55] ITK. (2016). "National Inuit Suicide Prevention Strategy." https://www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf

Implementation Team and close collaboration with ITK) and referencing pathfinder documents and research reports developed by partners. Regionally, MWP representatives discussed priorities through local partnership structures (e.g., working groups, co-management tables) and through direct engagement with funding recipients. Indirectly, key partner issues were also relayed between regional and national-level staff through regular mental wellness cluster meetings.

Almost all key informants (FNIHB, Inuit, First Nations) agreed that the funding through the MWP is relevant to the priorities of First Nations and Inuit, owing to its increased flexibility, recent funding enhancements, and investments in key issues identified by partners.[56]

With respect to flexibility, several representatives in both First Nations and Inuit contexts perceived the increasingly broad program authorities (terms & conditions) as a strength of the program as communities/organizations could deliver services that were tailored to their unique priorities and adapt programming as needed (e.g., during the COVID-19 pandemic). Specifically, the introduction of the Mental Wellness Alignment was cited as evidence of a shift in the program's design as it aimed to reduce siloed funding and enable greater opportunity for communities to customize their program objectives and activities (e.g., planning programs along a continuum rather than according to siloed FNIHB program plans), regardless of their type of funding agreement. As well, a few regional representatives described improved flexibility in supporting contribution agreement holders to plan and deliver programs according to local needs. For example, one Inuit representative explained that this flexibility was appreciated with the announcement of additional Mental Wellness Teams (MWTs) in 2016, as their region was supported to identify and prioritize appropriate roles for their team rather than focusing on western professional designations.

Throughout the evaluation timeframe, there were also increases in overall program investments in an effort to enhance services, respond to increasing demands, and support communities and organizations to overcome known **c**hallenges. Since 2015, total allocated funding for the MWP doubled from approximately $236 million in 2015-16 to $481 million in 2020-21.[57] This included investments in priority areas as highlighted below;[58] however, there was agreement across almost all key informants that funding within the program remained insufficient.

[56] A few indicated that funding would be more relevant with greater attention to capital needs and priority populations (discussed later).
[57] While not within the evaluation timeframe, since 2021, funding has subsequently doubled to $650M annually.
[58] Other funding announcements included the Hope for Wellness Help Line (2016), funding for community-identified priorities in MW (2017), the Youth Hope Fund (2017), funding for wraparound services at opioid agonist sites and bulk purchasing of naloxone (2017), the renewal of the IRS RHSP (2018), and COVID-19 related funding (2020).

Illustrations of Program Investments in Priority Areas

- Collaboration through the Mental Wellness Continuum Framework Implementation Team shaped investments in the MWP including **expansion of the MWTs and enhanced funding for crisis response capacity** (2017).
- Informed by partnership efforts with ITK, the **NISPS was funded in 2016 as an Inuit-led approach** to address and prevent suicide and additional funding was received through Budget 2019 to support continued implementation.
- To respond to recommendations that emerged from the National Inquiry Interim Report, **health and cultural supports were expanded** to survivors, family members, and others affected by the issue of MMIWG (2018).
- Budget 2017 provided ongoing funding for the Hope for Wellness Helpline (immediate support, available 24/7, for all Indigenous people). A chat service was added in 2018.
- Through Budget 2018, **enhancements were provided to treatment centres to address gaps in programming.** This was identified through regional and national partnership tables as partners outlined a need for more targeted substance use programming, such as opioid agonist therapy (OAT), supports for individuals with concurrent disorders, and supports for individuals who misuse prescription drugs.
- Budget 2020 provided funding for health and cultural supports for Survivors and Intergenerational Survivors of Federal Indian Day Schools.

Alongside these investments, several key informants (FNIHB, First Nations, Inuit) indicated that there had been **evidence of an overall shift toward recognizing Inuit and First Nations knowledge, values, and practices in supporting mental wellness** as demonstrated by federal investment in land-based and culture-based activities. For instance, Budget 2018 investments included a focus on increasing the reach of substance use prevention and treatment programming by expanding land-based healing programs.

"There has also been an uptake of including Elders on Mental Wellness Teams, so now you can talk to Elders if you're having a problem. Before, the recognition from FNIHB on the importance of Elders was maybe lip service, but now there's more funding to support Elders to be part of a session, to be on contract at the clinic. there is more effort to find out what works in community rather than apply a cookie cutter solution to everything. If it's working, do it. That's a huge improvement."

At the same time, the time-limited nature of some of these investments, coupled with "chronic underfunding" as reported by key informants, indicated that the program still did not keep pace with needs (see section 6.2).

Opportunities for Further Alignment

A few challenges and corresponding suggestions were identified to further align the MWP with the priorities of First Nations and Inuit.

Need for capital/facility investments. While not unique to the MWP, several First Nations and Inuit key informants noted that **the restrictions on use of community-based MW funding for capital expenses was an ongoing challenge** as there were often considerable needs for community infrastructure to support programming (e.g., confidential spaces for counselling services, cabins and cultural sites, youth-based centers). For example, a few Inuit representatives described how an organization may have identified a programming need and received corresponding funding, though was ultimately unable to deliver the program as there were no available facilities and funding stipulations restricted capital purchases. In some cases, this can lead to carry forward despite evidence of program need. First Nations representatives highlighted similar difficulties with limited spaces for program delivery.[59]

"The funding has to come with some idea of infrastructure for mental health and addictions, this part has been missing. People often think, 'well, you can just do this work anywhere.' Well, you can't. You need a safe, confidential space. We don't think about this in mental health, but it actually impacts a lot of the work that we do."

- Jose Pruden, Wellness Director, Battle River Treaty 6 Health Centre, Saskatchewan

"It's one thing to have a program, but it's another thing to have the place and space or the people to be able to deliver on that program's objectives. We need investments in infrastructure and not just programming funds. Things such as wellness camps to facilitate being on the land and connecting to culture for healing, this is really important to Inuit."

- Inuit regional representative

[59] Furthermore, the FPWC Comprehensive Needs Assessment Interim Report highlights that some communities may not have access to office and program spaces nearby and/or the spaces may not support privacy for community members.
Source: First Peoples Wellness Circle. (2019). "Mental Wellness Teams Comprehensive Needs Assessment Interim Report."

Federal/central agency funding stipulations. Some FNIHB representatives explained that funding stipulations introduced by central agencies have undermined the program's commitment to flexibility and self-determination. **While the MWP amalgamated many of its funding streams through the Mental Wellness Alignment, key informants felt that rigidity and administrative requirements were being re-introduced to funding recipients as some funding received for the program continued to be administered as 'add-on' funding for recipients to deliver within specified parameters, rather than as broad community-driven mental wellness funding.**

> *"What tends to happen sometimes is, in announcing a new priority or seeking money to a particular area of concern, you get budget approval, but it comes with a level of scrutiny at the Minister's level or central agency level*
>
> *-FNIHB Staff*

Population considerations. Some population-specific considerations were highlighted. While the program terms and conditions did not restrict population-specific services, **several key informants in Inuit and First Nations contexts suggested that there was an overall gap in mental wellness programs and services for some priority populations, including children, youth, and family-based supports.** This was often associated with an overall insufficiency in funding (i.e., children, youth and families services and supports can be funded under existing funding streams; most/all of funding is used for crisis or the highest need, leaving only a small portion available for prevention) alongside a lack of suitable facilities to deliver programs. Furthermore, a few indicated that programs may not have the capacity to meet the specific needs of 2SLGBTQQIA+ populations as staff may not have access to appropriate training while program spaces may not be perceived as safe and affirming.

5. Effectiveness

5.1 Successes and Impacts

Finding 3: Service access and uptake has grown. Regionally, First Nations and Inuit-led programs are showcasing promising approaches that are grounded in culture, strengths-based, trauma-informed, and responsive to priorities.

Access and Uptake

Reporting data from the IRS RHSP shows that the program saw a continued increase in demand over time as **the number of hours of mental health counselling sessions grew by 57% between 2015-16 and 2020-21, and the number of clients per health and cultural support worker nearly doubled.**[60] As indicated in section 4.1 above, numerous factors could explain this, including general growing need for services, the emotional impacts of settlement agreements, expansion of program eligibility access to mental health counselling services through the trauma-informed programs with the addition of the Missing and Murdered Indigenous Women and Girls Health and Cultural Support Program (2018) and Federal Indian Day Schools Health and Cultural Support Program (2020), increased dialogue and awareness of the experiences of IRS Survivors.

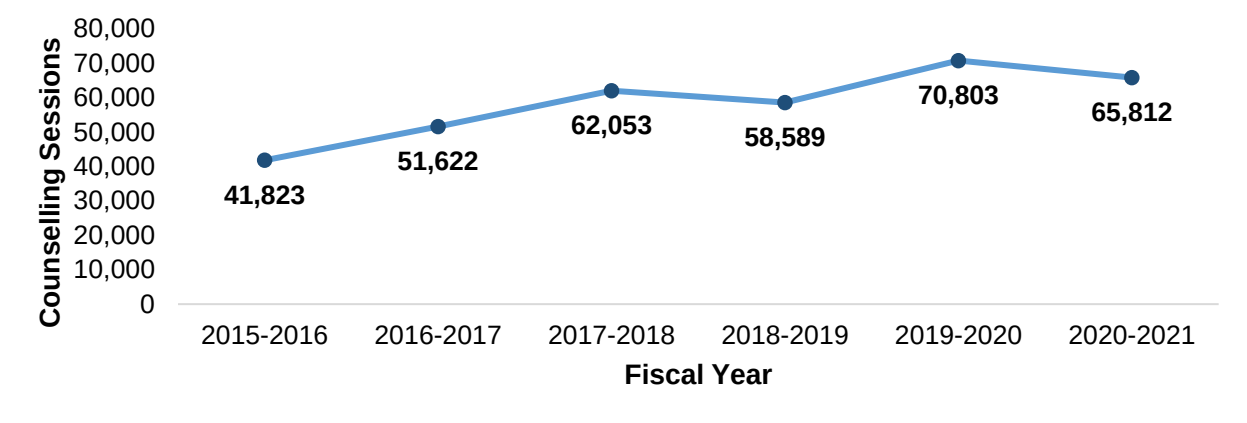


Figure 2. Number of hours of counselling sessions through IRS RHSP, 2015-2021[61]

Additional metrics that demonstrate growth in service access and uptake include:

- **Treatment Centres:** The table below shows an **increase in admittance numbers** for most services (in-patient, day patient, outreach/aftercare) based on available reporting data. Not displayed below, a review of the data also found that the proportion of treatment centres accepting clients on Suboxone increased considerably from 42% accepting Suboxone clients in 2015, to 71% in 2018, and the total number of clients admitted to centres grew from 3,646

[60] ISC. (2023). "Indian Residential School Resolution Health Support Program Mental Health Counselling Data"
[61] ISC. (2023). "Indian Residential School Resolution Health Support Program Mental Health Counselling Data"

in 2015-16 to 4,960 in 2017-18 (36% increase among treatment centres that completed reporting).[62]

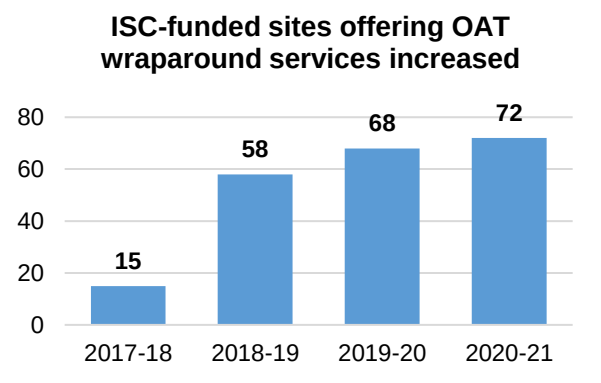
Table 4. Type of treatment centre services accessed by clients, 2015-2018[63]

Treatment Centre Admittance*	Reporting Year		
	2015-2016 (n=43)	2016-2017 (n=44)	2017-2018 (n=34)
# Accessing Inpatient Care	3,646	4,448	4,171
# Accessing Outpatient Care	3,382	2,791	2,686
# Accessing Day Patient Care	651	1,307	1,315
# Accessing Outreach-Aftercare	1,535	3,709	3,048

** Annual reporting data indicates that reporting practices and interpretation varied in some cases across treatment centres, resulting in some incomplete data.*

- **Mental Wellness Teams:** Reach of the MWTs increased with the 2016 announcement of funding for four crisis response teams in Ontario, Manitoba, and Nunavut, and an additional 32 MWTs. As of September 2021, there were an estimated 63 MWTs serving 344 First Nations and Inuit communities.
- According to departmental results data, **in 2019-2020, 50% of First Nations and Inuit communities had access to MWTs – an increase from 15% in 2015-16.[64,65]**

- **Opioid Agonist Therapy Wrap-Around Services:** Investments in 2017 supported increased access to OAT wraparound services (e.g., assessment, referral, treatment, counselling, cultural supports) at community-based opioid agonist treatment sites. **While barriers to accessing treatment still existed by the end of evaluated period, the number of ISC-funded sites that offer OAT wraparound services increased from 15 (2017-18) to 72 (2020-21).[66]**



A few key informants highlighted that while program reach and uptake can offer insights on changes within the MWP over time, these data do not convey the whole picture as it relates to the community and individual-level impacts of services offered (an area for investigation in Phase Two).

[62] ISC. National Treatment Centre Roll-Up Reports, 2015-2018.
[63] ISC. National Treatment Centre Roll-Up Reports, 2015-2018.
[64] ISC. (2020). "2019-2020 Departmental results report." https://www.sac-isc.gc.ca/eng/1603722953624/1603722975586
[65] ISC. (2017). "2018-2019 Performance Information Profile."
[66] Health Canada. (2023). "Horizontal Evaluation of the Canadian Drugs and Substances Strategy (CDSS): Evaluation Report."

Responsive Service Delivery

Discussions with regional Inuit, First Nations, and FNIHB representatives, alongside available reporting, suggest that MWP funding contributed to the delivery of responsive programs and services.

Illustrations of Impacts across Funding Areas

- **National Inuit Suicide Prevention Strategy:** Representatives within Inuit service delivery contexts highlighted that funding for the implementation of the NISPS was significant as it addressed a recognized gap in service availability following the closure of the Aboriginal Healing Foundation. **NISPS funding has supported the development of regionally tailored suicide prevention strategies and programs**. According to key informants and an Annual Report by ITK, examples of programs included youth wellness programming and a culturally rooted parenting program in the Inuvialuit Settlement Region; an Inuit counselling training and mentorship program and culturally based men's programming in Nunavut; positions for community members to deliver a land-based healing program in Nunavik; and an overnight youth drop-in centre and sexual violence prevention counsellor in Nunatsiavut.[67,68]

- **Mental Wellness Teams:** Representatives familiar with Mental Wellness Teams reported that the **expansion of the teams has contributed to improved crisis response capacity within communities and reduced the need for surge supports** (i.e., temporary crisis response support from individuals who may not have relationships within a community). Having a local team also supports long-term relationship building and continuity of care for community members. **MWTs have integrated culture-based care** into programming and services, supported individuals through a two-eyed seeing approach, and helped to introduce harm reduction models in communities.

[67] ITK. (2018). "Annual Report 2017-2018." https://www.itk.ca/wp-content/uploads/2018/08/ITK_AR2017-2018_English.pdf

[68] More recently, a 2022 budget submission prepared by ITK notes that there is an opportunity for enhanced support to enable a more holistic approach to suicide prevention at both the community and regional levels. The submission notes that COVID-19 was marked by an "unprecedented level of coordination and funding," and that similar efforts are warranted to address suicide as a preventable public health crisis in Inuit communities through greater support for the implementation of the NISPS.
Source: ITK. (2022). "Inuit Tapiriit Kanatami Pre-Budget Submission 2022." https://www.budget.canada.ca/2017/docs/plan/chap-03-en.html

"When I think of Mental Wellness Teams, we are seeing more of an ability for the Teams to provide in-community interventions and other supports and services. Because there was a large investment in 2017, communities may have previously only had one community worker, but the Mental Wellness Teams are giving access to crisis supports and response planning, they might be working in some communities jointly with emergency management and in pandemic planning."

- Dr. Brenda Restoule, CEO, First Peoples Wellness Circle

- **Treatment centres:** According to a 2017 report by the AFN, **treatment centres have evolved to meet needs, including by expanding their scope of practice** and treatment methodology from a generic residential treatment program to including community-based day treatment, outpatient care, and land-based activities, while also developing linkages to support population-specific needs (e.g., individuals with concurrent disorders, chronic health conditions, or who are prescribed OAT, women and families with children).[69] Treatment centre representatives also described offering day trips to visit local attractions, healing supports through cultural therapists and clinical therapists, ceremony, and medicine picking, and virtual programs/services for clients at home and awaiting treatment.

"I think because of the mental wellness program, people are trying to think out of the box, and stepping out of the old way of doing. I know a number of centers have gone to communities and got community feedback, to see how they can support communities in addressing challenges. I feel people are willing to step out of their comfort zone and try new things to increase positive outcomes within the programs."

-Treatment Representative

- **Indian Residential Schools Resolution Health Support Program:** A qualitative project led by First Peoples Wellness Circle gathered stories from Survivors who have interacted with the IRS RHSP. Published in 2021, the report concluded that **the program was meeting the unique needs of Survivors, their families, and communities in a number of ways.** Among them, the IRS RHSP was effectively connecting Survivors and their families to providers with a strong understanding of the deep-rooted impacts of Indian Residential Schools and with capacity to offer a cultural, strengths-based, and trauma-informed approach to healing. Comparatively, Survivors noted that external providers lacking cultural

[69] Assembly of First Nations. (2017). "The First Nations Health Transformation Agenda."

competence or without lived experience often did not have an adequate understanding of the impacts of colonial legacies, which has led to further harm. Through the RHSP, survivors have worked to restore relationships, venture on a path toward long-term healing, and connect with their cultural and spiritual identities. The assessment spoke to the strengths of the program and the need for the IRS RHSP to continue and evolve to meet the changing needs of IRS Survivors and those who are impacted by the intergenerational consequences of the IRS and other colonial legacies.[70]

External Factors Limiting Impact

Other factors limiting the MWP's ability to achieve impact were noted, which cannot be addressed through the program. All key informant groups agreed that the long-standing inequities in the social determinants of health experienced by many Inuit[71] and First Nations[72] has a significant impact on mental wellness. **In the absence of significant upstream investments, including in housing, community infrastructure, culture and language, health services, food security, clean water, employment, and education, programs delivered through the MWP have limited ability to meaningfully improve outcomes for community members.** The need for a holistic approach that is grounded in First Nations and Inuit-specific determinants of health has been continuously identified by partners and was also reiterated in the NISPS and the FNMWCF.

Relatedly, key informants reported that limited partnership and investment from provincial partners was a significant risk to achieving progress on regional priorities in collaboration with First Nations and Inuit. This included improving access to detox and effectively responding to drug-related crises including the opioid crisis.

5.2 Access to a Continuum

Finding 4: Findings from governance-level partners suggest that there were persistent challenges in access to medical detox services, case management and service transition, and access to treatment services and community-based substance use supports.

As described by several key informants and in program frameworks, **a comprehensive mental wellness system requires commitment across partners of various levels – communities, First Nations and Inuit regional entities, provincial and territorial governments, and the federal government.** While the Mental Wellness Program provides funding for some mental wellness services along the continuum, others fall within provincial and territorial health services (e.g., medical detox). Furthermore, the ability to deliver and access a full spectrum of care can vary regionally and across communities due to factors including human resource capacity, funding

[70] First Peoples Wellness Circle. (2021). "Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories."

[71] ITK. (2016). "National Inuit Suicide Prevention Strategy."

[72] Health Canada & Assembly of First Nations. (2014). "First Nations Mental Wellness Continuum Framework." https://www.sac-isc.gc.ca/eng/1576093687903/1576093725971

(i.e., funding amount, growth, duration), community size and available infrastructure[73] partnerships, cultural safety (e.g., of programs/services available in nearby centers), and remoteness.

Findings suggest that while funding through the MWP contributed to supporting access to a continuum of care, **there were ongoing challenges across regions in access to a comprehensive system of supports.** This appeared to be due to factors including limited jurisdictional coordination, difficulty accessing provincial/territorial services (e.g., medical detox, OAT prescribing), high demands on staff, and limited funding to deliver a comprehensive program/service plan**.** The key themes that emerged align closely with findings from the previous evaluation; however, validation from community-based perspectives is warranted.

Detoxification

Medically based detoxification services are the responsibility of provincial health authorities and are not funded through the MWP. **Insufficient access to medical detox services was a key theme** in discussions focused on First Nations contexts and **almost all regions cited this as an area of need**. Due to issues associated with provincial shortages in services, as well as community remoteness from services and lack of culturally safe detox facilities, individuals can face significant barriers to accessing treatment. Some FNIHB regions have attempted to mitigate this challenge by focusing on home and community detox models.

Inuit representatives did not specifically comment on detox access, however an overall finding across several key informants was the **absence of Inuit-based substance use programs** and services, including in-territory treatment and harm reduction measures.

Case Management and Coordination

System navigation was highlighted by a few First Nations representatives as an area of need, particularly for individuals with complex needs or who were interested in accessing detox and treatment services. **In particular, a few described challenges with case management in the transition between detox services and treatment**, and upon **exiting treatment and returning to community** (e.g., supportive housing, recreation, employment, food security), which can lead to further harm for individuals and "put them in a cycle." This was attributed to limited human resource capacity to undertake case management activities against a highly demanding workload. However, greater input from community-based staff is required.

Treatment Services and Substance Use Supports

[73] As smaller communities receive less in funding compared to large communities, the scope of services may also be limited to those that are of the highest priority rather than a comprehensive system of care.

All key informant groups reported challenges in access to treatment centres as an area of concern due to long wait lists, intake models (i.e., lack of continuous intake),[74] geographic distance between treatment centres and communities (particularly for communities in the North), a fragmented transition processes between provincial detox facilities and treatment centres, and confusion with respect to travel eligibilities to access federally funded treatment centres in other locations. A few Inuit representatives also questioned the scarcity of in-territory treatment against concerns over growing and evolving substance use.

> *"What we're seeing right now is that treatment is often the first resort at many community levels. It should be the last resort, but there is a lack of early prevention and intervention programs for families."*
>
> *-Treatment Centre Representative*

At the same time, some key informants in First Nations contexts stated that there were overarching and significant challenges in access to community-based substance use services, including addictions medicine, outreach and peer support, harm reduction supplies, and culturally relevant public health and primary care services. Therefore, a few noted that **treatment centres experienced high pressure to resolve all unmet needs and faced undue criticism** against a broader issue of chronic underfunding of addictions services, racism within the health care system, and lack of multi-jurisdictional partnership and investment to address gaps in the mental health and addictions landscape.

5.3 Partnerships and Collaboration

Finding 5: Partnerships are important for supporting the MWP to respond to priorities and for advancing a coordinated system of care. Yet, a lack of provincial partnership and investment is an enduring challenge that has impeded progress and led to duplication.

National Partnerships

National partnership and collaboration efforts were generally seen as effective to advancing mutual priorities. Inuit representatives described the program's engagement approach as responsive, transparent, and frequent, which helped to advance Inuit priorities including investment in the National Inuit Suicide Prevention Strategy. First Nations representatives indicated that program representatives were receptive to partner input and that recognition of priorities outlined in foundational documents (i.e., First Nations Mental Wellness Continuum Framework, Honouring our Strengths) has increased across the Branch. FNIHB staff felt that partner influence was a critical facet of the program, which informed measures such as the Mental Wellness Alignment and the MWP's response to the opioid crisis (e.g., Opioid Agonist Therapy wrap-around, harm reduction measures). Furthermore, the First National Mental Wellness Continuum Framework Implementation Team supported a cross-government approach to facilitate knowledge exchange, develop partnerships, and drive systems change. There was an

[74] At the same time, a few explained that block or cohort-based models are important to building safety and trusting relationships among clients accessing treatment.

overall perception among some key informants that engagement efforts had become increasingly prioritized over time, including at a branch level, department level, and in linkages with other federal departments (e.g., Justice Canada, Public Safety).

Some challenges were also identified by key informants (i.e., restrictive timelines, capacity, government processes), which are displayed in the table below.

Table 5. Reported challenges to partner engagement within the MWP

What are the challenges to meaningful collaboration?
• Restrictive and short-term government timelines limited respectful engagement
• Partners are restricted from secret-level processes (e.g., budget proposals)
• Imbalance in staffing between federal teams and partner organizations
• Lack of funding available to mobilize partner priorities
• Desire for greater internal partnerships (within Government of Canada, ISC and FNIHB) and action on systems change (e.g., the social determinants of health)

Provincial Partnerships

Across regions, bilateral and trilateral partnership structures existed with First Nations to support joint planning and priority setting (e.g.., between provincial/regional provincial governments and/or organizations, First Nations, and FNIHB). Some examples of improved partnership were noted, including joint provincial-federal funding of Ontario Mental Wellness Teams (see Highlight Box for additional detail). One region also described working collaboratively with FNIHB representatives, a regional health authority, local First Nations leaders, municipal representatives, and a local opioid agonist therapy site to address high rates of human immunodeficiency virus (HIV) within the area. In another region, partnership efforts between FNIHB, a regional health authority, and a nearby Nation supported the community to secure a nurse practitioner to assist with an OAT program. However, **most regional representatives described a lack of engagement and support from provincial partners as a considerable challenge** that created service duplication, impeded progress in addressing key regional issues, and led to federal funding being used to overcome gaps in services that fall within provincial jurisdiction.

An example shared by key informants was the federal MWP investment in wraparound services at opioid agonist therapy sites, though regional FNIHB staff questioned the provincial provision and availability of OAT services in nearby communities altogether. Similarly, regional key informants described limited access to provincially based detoxification services as a significant unmet need.

"There is a presumption that the province is setting up OAT treatment services because it's primary care, it requires medication dosing, clinical oversight, and then this funding will wrap around it. But that OAT program didn't exist."

- FNIHB Staff

Similarly, reports from partners highlight **a need to increase meaningful trilateral discussions that are action-oriented, coordinated, and within a clear shared understanding of jurisdictional responsibilities**.[75] One key informant recommended that this could include dedicated funding for regional, tripartite strategic planning to develop a coordinated approach to responding to key priorities.

Sharing Successes: Regional Partnerships

- **Expansion of Mental Wellness Teams:** A few key informants highlighted that a successful partnership exists in the Ontario Region through the joint funding of 20 MWTs by the MWP and the Ontario Ministry of Health. As the regional funding allocation for MWTs was limited, provincial mental wellness funding was successfully leveraged to expand coverage to over 100 First Nations. One key informant described expanded access to the teams as successful for improving community-based crisis response planning and capacity.

Territorial Partnerships

Within the northern region, seven bilateral and trilateral partnership structures exist to engage territorial governments, Inuit regions, and First Nations. While not all territorial partnership models could be extensively explored, some examples of successes were reported. For instance, the Nunavut Partnership Table on Health was highlighted as effective for advancing regional progress in in-territory substance use treatment. Following a feasibility study conducted by the territorial government, the need for a territorially based, culturally appropriate, and Inuit-led substance use treatment centre was highlighted. Through the table, a tripartite Memorandum of Understanding was developed for an Inuit-led treatment and recovery centre (Aqqusariaq) with shared support from FNIHB, the government of Nunavut, and Nunavut Tunngavik Inc. More broadly, key informants reported the table to be effective for raising emerging issues within the territory and coordinating a response between partners (e.g., the COVID-19 pandemic response, tuberculosis clinics).

Bilaterally, Inuit regional representatives also described their collaboration with FNIHB as effective to discussing their needs and priorities (discussed below).

6. Design, Delivery, and Efficiency

6.1 Design and Delivery of Funding and Support through the MWP

Finding 6: The MWP undertook efforts to enhance flexibility and reduce funding siloes through the introduction of the Mental Wellness Alignment. Preliminarily, the Alignment supported more flexibility across funding streams, though building awareness of its intent and purpose should continue.

[75] First Peoples Wellness Circle. (2019). "Mental Wellness Teams Comprehensive Needs Assessment Final Report."

Mental Wellness Alignment

The introduction of the Mental Wellness Alignment was a primary change within the MWP during the evaluation timeframe and responded to recommendations from partners and the previous evaluation. While the impacts were not yet fully known, some key informants felt that the Alignment had enabled greater flexibility for communities to plan and deliver programs holistically as recipients were not required to manage siloed funding and reporting accountabilities between several individual programs. Preliminarily, this supported recipients to better align programs with the vision and priorities within their community or organization.

> *"When the Alignment came into play, I saw a huge shift in independence and autonomy [of funding recipients] to direct and have a very specific approach to how they provide mental wellness services to Nations. It also allows for them to plan ahead in terms of goals, knowing they can utilize funds as needed. It's also assisted in having a clear picture on where their gaps are, so being able to articulate what the additional needs are. That Alignment has assisted with that planning, and more sustainable and long-term provision of funding for specific programs and services for [Nations]."*
>
> *-FNIHB Staff*

Some felt that the opportunities introduced through the Alignment had not been leveraged equally, primarily due to variation in capacity to engage in health planning, as well as available program resources and facilities within a community. **Others felt that there was some confusion with respect to the purpose of the Alignment and which funding streams had been collapsed, indicating a continued need for the MWP to build awareness of its intent.**

Internally, a few FNIHB representatives highlighted greater complexity with financial tracking, given that the Alignment consolidated many program funding streams that were "not all created equally" (i.e., not all programs were growth eligible, some funding was time-limited). As a result, this created challenges to track and manage available funding within the MWP.[76]

Finding 7: Regional First Nations and Inuit regional respondents generally perceived FNIHB-MWP staff as supportive and flexible. Some opportunities to improve were identified (i.e., internal management, communication, and engagement).

Delivery of Support

Alongside the delivery of funding, regional FNIHB staff supported First Nations and Inuit to deliver mental wellness programs through:

- **Communicating and responding to questions** regarding contribution agreements, program terms & conditions, reporting requirements, and funding eligibilities.

[76] For example, having the ability to track funding that is time limited versus ongoing was cited as a more challenging internal exercise for regional teams following the alignment.

- **Offering advisory and technical support** where requested, such as reviewing funding proposals and contributing to health planning, work plan development, and funding reports.
- **Supporting internal system navigation** by linking communities/organizations with other directorates or funding areas (e.g., infrastructure, nursing, Jordan's Principle, Non-Insured Health Benefits).
- **Linking communities/organizations to workforce development and training resources** advanced by Indigenous partner organizations;[77] and
- **Communicating announcements and changes** introduced within the MWP, such as the Mental Wellness Alignment.

A key strength of the approach taken by FNIHB staff was their flexibility, as reported by several Inuit and First Nations representatives. **Through a hands-off approach, regional staff enabled communities and organizations to advance their priorities while offering guidance and problem-solving when needed**. A few Inuit representatives also reflected upon the efforts of FNIHB program representatives in supporting organizations facing challenges through contributing budgeting and work plan support and co-creating funding reports to avoid funding being stalled.

> *"ISC has also been very supportive from what I've seen since 2018, they have been very supportive of these organizations as they go through ups and downs. That is fantastic. They have helped organizations that are struggling to get back on their feet and delivering quality programming."*
>
> *-Anonymous*

Some areas for improvement to enhance support through the program were shared during primary data collection, as displayed below.

[77] While some training opportunities might be delivered in-house by FNIHB, key informants noted that the program has increasingly transferred training and capacity building activities to Indigenous partners.

Suggested Areas for Improvement to Enhance Support

- **Improve internal management within ISC** to avoid misplaced funding reports and disruptions due to frequent turnover of staff. (Reported by First Nations and Inuit)
- **Strengthen communication and engagement efforts** to ensure that regional and community priorities are well-understood, and that agreement holders are sufficiently aware of the program terms and conditions, program changes, and new or relevant funding opportunities. (Reported by First Nations and Inuit)
- **Stay consistent with reporting requirements** as much as possible, given the time required to adjust reporting systems on a community/organizational level. (Reported by First Nations)
- Advance mechanisms for **simplified needs-based funding** to efficiently support communities during emergencies. (Reported by First Nations)
- Continue to **streamline funding** and avoid multiple or adding of new funding streams (i.e., there are some streams of funding that continue to exist outside of the aligned Mental Wellness Program). (Reported by Inuit)

Internal Program Efficiency

FNIHB representatives reported that the internal structures and collaboration between the national office and regional offices were operating efficiently to discuss concerns and advance priorities. Strengths included:

- The **responsiveness** of the national office;
- Having **simplified administrative processes**;
- **Connecting regularly** through regional cluster meetings; and,
- **Having regional flexibility** to develop tailored structures to engage and support communities (e.g., interdisciplinary teams within FNIHB)

Some suggestions for improvement were reported. **Almost all regional staff felt they are being reactionary in their support to funding recipients due to high staff turnover within the branch and the large volume of requests received.** A few FNIHB representatives also felt that there were opportunities for more timely engagement between their region and the national office (e.g., in funding and policy processes) to ensure that local priorities identified by partners were understood and reflected in submissions.

6.2 Capacity to Deliver Services and Meet Needs

Finding 8: There was strong agreement that available financial resources within the MWP do not meet the demands for services, which greatly affect the ability of Inuit and First Nations to meet needs, develop stable operations, and retain a healthy workforce.

Program Resources

During the years covered by the evaluation, the MWP was allocated a total of $2.07B and expended $2.18B. Of the total spent within the MWP, 89% was flowed through grants and contributions, 7% on operating expenses, and 3% on salaries. Total funding allocated to the program approximately doubled, and there was a 56% increase in contributions spending (see: Table 2).

Despite additional investments, there was strong agreement across all lines of evidence that **the available funding was not sufficient to meet the expected outcomes of the MWP and that funding had not kept pace** with the following factors: population growth and the true number of populations reached through a service, inflation and increasing costs, competitive salaries, increasing pressure on the programs, and the complexity of service delivery (e.g., for remote and isolated services and clients with more complex needs). For example, interviewees spoke to additional funding needed for Mental Wellness Teams, community-based programming supports, and substance use prevention and treatment; however, key informants were not asked to comprehensively assess all streams of the Program.

Additional financial data was requested to support a more robust examination of program funding (e.g., analysis of the proportion of core funding versus time-limited funding; proportion of funding that is growth eligible) and assess whether funding policies are aligned with broader federal commitments to reliable and flexible funding. However, a detailed quantitative assessment of program resourcing over time was challenging due to the complex nature of funding. Investments are a mix of on-going and time limited funding with some being demand-driven, some being flexible to needs, and a small portion being proposal based. Furthermore, target populations for investments differ across and within funding streams. As previously noted, program documents indicated that in 2016, less than half of mental wellness funding included a 3% annual escalator. FNIHB staff also reported that, at that time, about half of total program funding was time-limited, and though the program received additional funding during the evaluation timeframe, most was not ongoing funding. For example, of the increased allocation to the MWP between Fiscal Years 2019-20 and 2020-21 ($86.05M), the data suggests that 86% ($74.006M) of the increase was due to time-limited COVID-19 pandemic funding.

Nationally, MWP representatives described various approaches to allocating program funding to regions, including through the modified Berger formula,[78] base funding, demand-driven funding[79] and/or factoring in regional need/priority. However, a report prepared by the Thunderbird Partnership Foundation in 2022 suggested that funding formulas, including the Berger and modified Berger, were considered outdated as they underestimate the resources required to effectively deliver programming in today's realities.[80] For this reason, **partners have advocated (within the MWP and more broadly) that federal funding formulas be improved** to better

[78] The Berger formula was developed in 1982 and adjusts to population based on the distribution of people across each region in terms of remoteness and size of community.
[79] IRS RHSP O&M for mental health counselling is demand-driven, meaning that the branch receives an allocation each fiscal year, and expenditures depend on utilization of services, with registered mental health providers reimbursed on a fee-for-service basis.
[80] Thunderbird Partnership Foundation. (2022). "Building Sustainable Equity, Retention, and Capacity in First Nations Addictions Treatment Programs."

reflect factors including need/demand, populations reached, wage equity, capacity building, and complex service delivery contexts (i.e., for remote, isolated, and northern communities). Several analyses at National Office have been completed around need/demand driven formulas with a key limiting factor being lack of reliable and relevant data around need and demand.

> *"Having these incredibly flexible, broad parameters, on the one hand, has the benefit of making space for communities to do what they prioritize, but it's a bit disingenuous. If someone were to look at the plan, they might say 'oh wow, I can't believe ISC is funding that.' But the reality is that we're not. […] Most communities have less than $75,000 a year to cover this massive continuum of care, and that's inclusive of needing to pay for the salaries."*
>
> *-FNIHB Staff*

According to key informants and program documents, uncertain and limited funding can greatly impact communities and organizations in a multitude of ways, including their ability to:

- **Recruit and retain qualified staff** at competitive wages
- **Develop stable operations** within their organization
- **Invest in training** and build/**restore capacity**,
- **Expand and innovative programming** (e.g., land-based programs, population specific programs)
- **Plan a spectrum of services** across the continuum, investing in prevention programs/approaches that focus on the root cause[81]

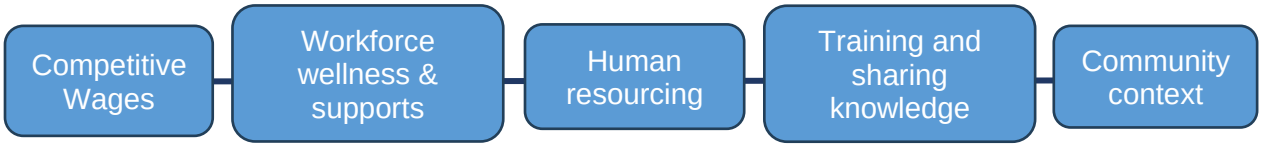
To help mitigate funding limitations, First Nations and Inuit regional representatives reported seeking funding through Jordan's Principle and the Inuit Child First Initiative and leveraging multiple funding initiatives (e.g., Tobacco Strategy funding, other project-based funding) to deliver programs.

Community and Workforce Capacity

In addition to addressing resourcing, all lines of evidence highlighted that fostering a healthy and qualified mental wellness workforce is foundational to achieving meaningful outcomes in mental wellness services. An overall theme from the interviews and document review suggests that, while there was notable diversity in workforce needs across and within First Nations and Inuit contexts, there were common considerations broadly affecting community and workforce capacity. These factors are illustrated below.

[81] Some key informants described that with underfunding of programs, communities may be left in a cycle of constantly responding to crisis events rather than investing in preventive approaches that address the root cause and support well-being.

Figure 3. Illustrations of factors which can affect the mental wellness workforce



Spotlight of Workforce Needs

According to key informants and the document review, First Nations and Inuit programs can face challenges in recruiting and retaining a qualified, culturally competent, and healthy mental wellness workforce due to many interrelated factors.

- **Human resource shortages.** Workforce shortages, including Indigenous substance use workers, were highlighted by some key informants as an ongoing challenge affecting the MWP due to factors including lack of competitive wages, recruitment and retention practices of provincial, territorial, and federal governments (e.g., recruitment to the Non-Insured Health Benefits Program), vicarious trauma and burnout, and an ageing workforce. For example, many cultural and emotional support workers within the Trauma-Informed Health and Cultural Support programs are Elders and survivors of the IRS, IDS, and Sixties Scoop and are transitioning out of the workforce. Accordingly, key informants expressed a great need for mentoring and support for the next generation of support workers.

- **Competitive Wages.** While a comparative analysis of wages against provincial and territorial data was not within the evaluation scope, findings from some key informants and research reports suggest that **there were continued challenges associated with competitive compensation.** One study published by the Thunderbird Partnership Foundation showed that **First Nations substance use workers earned approximately 45% less** than their provincial counterparts despite high rates of accreditation and certification, which is attributed to outdated funding formulas.[82] Similar data was not available in Inuit service contexts. Some improvements may be evident with the availability of additional funding through Budget 2018, though key informants perceived competitive wages to be a continued systemic challenge due to the nature of time-limited enhancements.

- **Training, sharing knowledge, and restoring capacity.** The need for support to access training, knowledge sharing, and capacity building opportunities were identified based on a needs assessment conducted by the First Peoples Wellness Circle,[83] an environmental

[82] Thunderbird Partnership Foundation. (2022). Building Sustainable Equity, Retention, and Capacity in First Nations Addictions Treatment Programs.
[83] First Peoples Wellness Circle. (2019). “Mental Wellness Teams Comprehensive Needs Assessment Final Report.”

scan across the Inuit regions,[84] and interview discussions. This included access to peer support networks and training focused on topics such as complex trauma, Indigenous-guided critical incidence and stress management, and land-based healing.

- **Community context:** Some key informants explained that workforce needs can be magnified in remote, isolated, and northern communities due to high turnover rates, shortages of local, culturally competent staff, lack of housing in community and dedicated spaces for programs, lack of community resources to support additional infrastructure, and greater compensation required.

Key informants shared several suggested opportunities for both the MWP and the broader department to address workforce needs in partnership with communities:

- **Leveraging and building awareness of resources developed by partner organizations** (e.g., workforce wellness strategies, training modules)
- Development of a **health human resource strategy**, which could include laddered training and engagement of younger populations
- Enhancing the **Aboriginal Health Human Resource Initiative** allocations
- Supporting **training opportunities that are close-to-home** (e.g., in-territory training) and grounded in First Nations and Inuit worldviews

6.3 Departmental Transfer from Health Canada to ISC

Finding 9: Efforts by the MWP to reduce siloes and support efficiency were observed through the transfer of FNIHB to ISC. The opportunities introduced through an integrated department could be further maximized.

With the creation of ISC in 2017, FNIHB was formally transferred from Health Canada to the new department, bringing together social, health, and infrastructure services, from both Health Canada and Indigenous Affairs and Northern Development Canada. The 2018-19 Departmental Plan stated that the primary mandate of ISC is to improve the quality of services delivered to First Nations, Inuit, and Métis peoples by working to close socio-economic gaps and ultimately ensure that Indigenous peoples have control over services and programs.[85]

Key informants generally did not perceive any direct, program-level impacts to the MWP following the department's creation. More broadly, several considerations (strengths and opportunities) were identified following the integration of FNIHB within ISC.

[84] ITK. (2019). NISPS Scan of Promising Practices. https://www.itk.ca/wp-content/uploads/2019/07/20190726-NISPS-ScanOfPromisingPractices-FINAL-EN.pdf

[85] ISC. (2019). "2018-2019 Departmental Plan." https://www.sac-isc.gc.ca/eng/1523374573623/1523904791460

Intra-departmental collaboration and partnership. Approximately half of FNIHB staff felt that aligning various Indigenous-specific programs and services under a common mandate was advantageous as it encourages a more coordinated and collaborative approach to supporting First Nations and Inuit. For instance, this led to opportunities for shared learning and fostered joint discussions to address key overlapping issues (e.g., child welfare, community safety).

At the same time, several FNIHB staff and First Nations representatives felt that intra-departmental collaboration could be further leveraged as programs and service areas continued to operate in siloes despite the multi-faceted nature of many priority issues affecting mental wellness (e.g., the social determinants of health). This was attributed to factors including:

- A **lack of internal capacity**,
- A **lack of departmental direction**, and
- A **program-by-program approach** to funding and supporting communities

"Some of the pros are being able to work more collaboratively with regional operations when communities go into crisis. What was challenging prior to ISC was, [FNIHB] would do our own calls with the community, and then [Indigenous Affairs and Northern Development Canada] regional operations would have their own calls if necessary. But they weren't jointly together. Now, when a community declares a state of emergency, it is FNIHB, Regional Operations, and our provincial colleagues. So, together, we're able to kind of cover off more ground, and be more flexible and creative."

Relationships and engagement. Key informants suggested that while the creation of ISC supported a more collective focus, there were differences across the department with respect to partner engagement processes and relationship building, citing some areas as reputed to be historically inflexible, risk averse, and less relational. Some First Nations partners agreed with this sentiment and suggested that the creation of a new department by amalgamating parts of two independent departments added, rather than removed, bureaucratic layers. However, it is important to note that some Inuit representatives held the opposite view, that the department's creation had led to improved relationships and more flexibility (e.g., in how FNIHB/ISC staff work with partners) as compared to other federal departments (including Health Canada).

Departmental efficiency. Some felt that there were inefficiencies associated with more complex budget submissions and corporate reporting, additional policy layers (e.g., FNIHB Strategic Policy and ISC Strategic Policy), and duplication in governance structures (e.g., committees, working groups) which had not yet been resolved. As well, a few perceived the MWP to have more

difficulty in effectively advocating for funding against other priority areas (e.g., housing, education), given that the impacts of public health programming were difficult to capture in the short-term.

6.4 Performance Measurement

Finding 10: Demonstrating performance within the program is challenged by reporting processes (i.e., streamlined reporting), available indicators and outcomes, and short timeframes of investments. Performance measurement approaches could be improved by applying First Nations and Inuit concepts of wellness and supporting capacity to collect meaningful data to inform planning on the basis of these concepts.

The 2016 Mental Wellness Program Evaluation outlined several recommendations related to performance measurement within the program, including:

- **Developing a comprehensive Performance Measurement Strategy** to guide the collection and use of performance data
- **Supporting community capacity** through sharing best/promising practices
- **Continuing to conduct special research studies** focused on specific areas within the program

Following the evaluation, a program Performance Measurement Strategy was developed with a revised logic model, program outcomes, and performance indicators. The Strategy also included detailed information regarding the department/organization responsible for collecting the information, the frequency of data collection, and how the data was collected. Further to this, the MWP supported the development of the partner-led “Wise Practices for Life Promotion,” an on-line resource focused on elevating the good work underway in First Nations communities across Canada and built on work funded by the MWP that was published in 2009. Several special studies were also conducted by partner organizations throughout the evaluation timeframe, including research assessments focused on the National Aboriginal Youth Suicide Prevention Strategy, Mental Wellness Teams, Indian Residential School Resolution Health Support Program, and treatment centres as well as an ITK commissioned evaluation of the National Inuit Suicide Prevention Strategy, which provided nuanced findings with respect to needs, impacts, and opportunities for the MWP.

While the MWP undertook efforts to improve performance measurement, some challenges were identified through the document review and primary data collection:

> *When we talk about investments and impacts, they're having an impact and making a difference, but so many things pop up that we're just treading water. It's hard to attribute progress when the issue you're trying to address keeps growing. To measure that is almost impossible."*
>
> *-FNIHB Staff*

Complexity of demonstrating impact: Some noted that there are several factors that can make it difficult for the MWP to demonstrate the impact of funding investments through the existing reporting mechanism and tools. This included the complexity of individual and community mental wellness and public health emergencies (e.g., opioid crisis) against short investment timeframes (e.g., 2 years), the role of many partners, jurisdictions, and sectors in delivering mental wellness services, and the program's continued focus on reduced reporting and flexible funding.

Outcome measurement and data availability: According to the Program's 2020 Performance Information Profile (PIP), **the risk of not having sufficient information for decision-making was noted as "very high".**[86] In-line with this, a review across the Performance Information Profiles (PIPs) available as part of the evaluation (2017-2018, 2018-2019, and 2020-2021) found that there were considerable changes to both expected program outcomes (long, medium, short term) across the documents and to the relevant indicators, which the program implemented in an effort to align with changing policies, increased flexibility and reduced reporting requirements. Some indicators were decommissioned and no longer collected (n=6) and others were newly introduced (n=3), and some performance indicators did not have established targets (n=3). As the MWP logic model was also updated during the evaluation period (with a focus on more broad short term, medium term, and long-term outcomes), some of the performance indicators in the most recent PIP did not align with the revised expected outcomes (e.g., "increase in healthy behaviours" was removed from 2020 logic model).

Measures of interest: Alongside measurement and attribution challenges, FNIHB Staff noted that the MWP received additional requests from central agencies and other areas of government to report on investment impact (e.g., "on-the-ground data" in addition to annual reporting data), despite the department's focus on reduced reporting; further to this, the indicators of interest were often western, deficit-based measures that are used by a range of organizations (e.g., suicide rates), which may not align with Inuit and First Nations worldviews on wellness (e.g., strengths-based, holistic).

Community/organizational capacity: Some First Nations and Inuit representatives also expressed a need to focus on increasing the capacity and resources available to community-based staff to ensure there are adequate data systems, processes, and strategies in place to collect meaningful data. While not widely validated by communities, it was also suggested by a few that the required reporting data might not be relevant to

[86] ISC. (2020). Performance Information Profile.

support long-term planning within communities. The list below presents opportunities to improve performance measurement as identified by key informants during primary data collection (FNIHB staff, First Nations, and Inuit representatives). Some of these opportunities could potentially be implemented within the program in the short to medium term (e.g., 1, 3, 4, 5), whereas others may require a more systems-level approach that goes beyond the MWP (e.g., 2, 6).

1. Increasingly emphasizing qualitative approaches (e.g., program and community stories) and providing partners with more formats for reporting outcomes to demonstrate impacts of investments

2. Continuing to build awareness and understanding within government of the department's commitment to flexible and streamlined funding and reporting approaches

3. Collaborating with partners (nationally and regionally) to ensure reporting and performance measures are relevant (e.g., hosting strategic planning sessions with regional agreement holders to co-define reporting measures of interest)

4. Continuing to support assessments and special projects conducted by national partner organizations to gather comprehensive sub-program and thematic findings.

5. Leveraging existing frameworks that advance First Nations and Inuit strengths-based perspectives on mental wellness outcomes and mapping the MWP's performance measurement approach against these outcomes (e.g., First Nations Health Managers Association wellness indicators, Inuit indicators of wellness)

6. Focusing on supporting community capacity for monitoring and evaluation activities that can help to inform long-term planning and control over services (e.g., measurement planning workshops, developing and sharing resources, learning from existing data)

7. Thematic Areas

7.1 Children, Youth, and Families

Finding 11: Both Inuit and First Nations representatives described youth-based mental wellness programming and services as an area requiring increased attention within the MWP and across the department.

Youth and family-based programs were described by approximately half of all key informants as an area of priority. While many First Nations and Inuit youth experience good health, some pointed to a great need to support youth impacted by intergenerational trauma and in the wake of many destabilizing events including the continued systemic and interpersonal racism, grief and loss, suicide clusters, environmental emergencies, findings from truth gathering processes, opioids and other substance use crises, and the COVID-19 pandemic. As well, a few key informants within remote, isolated, and northern contexts highlighted that youth can face unique challenges due to an overall lack of services available (e.g., mental health therapists), feelings of isolation (e.g., when travel out of community is difficult), limited programming (e.g., recreational activities), and stressors associated with the social determinants of health (e.g., food insecurity, inadequate housing).

Notwithstanding the importance of flexibility for regions and communities to identify and deliver programs in-line with their unique priorities, several key themes emerged with respect to perceived overall gaps in service offerings:

- **Strengths and resiliency-based youth programming** (e.g., focused on cultural identity, peer relationships, land-based and traditional)
- **School-based initiatives** (e.g., in-school counselling services)
- **Family-based programs**; and
- Youth and family-based **treatment centre services**

"Everywhere we go, every workshop we have, the youth will ask for more to do. Because of boredom, there's a lot of vandalism and they simply have nowhere to go. In the south, there are parks and malls, here, there aren't any. There are no public spaces or malls. Youth are always asking for a youth drop-in centre, and again we can't do it, because there isn't space."

-Territorial Mental Health and Addictions Representative

"I think there's been a lot left to be desired in terms of supporting that youth population. […] We've seen funding come through for adult treatment centers, whereas what we're really hearing is we need supports in the schools. There are programs that are funding activities, whether that's Head Start or Child and Family Services, but there isn't a mental Wellness component to it, and every sector across the board and community right now, it's like that's the presenting issue."

- FNIHB Staff

Against this, various **challenges were highlighted with respect to the capacity of communities/organizations to support youth and family-based services**. As previously mentioned, Inuit representatives highlighted challenges associated with a shortage of program spaces and understaffing, which led to unspent funding in some instances. First Nations representatives highlighted similar difficulties (program/recreation spaces, capacity), and also noted that **when communities encounter persistent crises, already-limited funding for prevention activities can be eroded.**

Some felt there have been limited targeted funding enhancements within the program to address these needs (while acknowledging that funding does not currently restrict programming for these populations.[87] As well, while there are adjacent programs that fund activities for youth and families (e.g., FNIHB Healthy Child Development program, Jordan's Principle, Child and Family Services), there is often not a mental wellness component to them and there are challenges to working across programs due to different target populations as well as terms and conditions. This suggests that there may be an opportunity to improve intersections between programs through more collaborative work. **A few FNIHB representatives also perceived an overall lack of coordination across ISC** for youth programming, leading to concerns that youth are "falling through the cracks." An exception to this coordination challenge was identified within the FNIHB Ontario region through the clustering of other funding envelopes (see: regional spotlight).

Regional Spotlight: Addressing Needs for Children and Youth

Key informants in the Ontario region described a promising approach whereby funding for the FNIHB Healthy Child Development program was also "clustered" as with the Mental Wellness Alignment. According to FNIHB staff, this change has supported communities to "tie in" funding between the two programs in an effort to fill gaps.

7.2 Climate Change

Finding 12: Climate change is disrupting important and distinct pathways for good health and well-being among First Nations and Inuit (e.g. access to traditional activities, emergency events) in complex ways that will further challenge the MWP operating environment and increase need.

Climate change is disrupting many of the determinants of well-being for Indigenous peoples, and which cannot be addressed through the MWP alone, particularly as there are programs, such as FNIHB's Environmental Public Health Program, and departments, such as Health Canada and Environment and Climate Change Canada, leading this file. A 2022 report by the National Collaborating Centre for Indigenous Health summarizes some of these pathways:[88]

87 It should be noted that ongoing funding exists through NAYSPS, and ongoing limited funding is available through opportunities such as the Youth Hope Fund.

88 National Collaborating Centre for Indigenous Health. (2022). "Climate change and Indigenous peoples' health in Canada." https://www.nccih.ca/Publications/Lists/Publications/Attachments/10367/Climate_Change_and_Indigenous_Peoples_Health_EN_Web_2022-03-22.pdf

- **Limited ability to hunt, fish, trap, forage, and spend time on the land**, which is a critical pathway to mental health and well-being
- **Disruption of the transmission of intergenerational knowledge and land skills** to younger generations, which is a critical component of cultural identity
- **Dislocation and damage to lands through extreme climate events**, such as wildfires, can create perpetual experiences of stress and ecological grief

> *"That impacts mental wellness for Inuit more than people realize, because when you're not used to the changes in the migration of animals or sea ice conditions, you might not be able to have a successful hunt. This not only impacts the hunter's family, but also who they would normally share their food within the community, creating food insecurity, which also impacts mental wellness."*
>
> *- Key informant*

The unique effects of climate change for communities in the North are increasingly documented and reported. For Inuit in Inuit Nunangat, the literature suggests that climate change is disrupting many activities that are beneficial for mental wellness, including spending time harvesting, fishing, and preparing country foods, traveling to cabins, and accessing culturally significant sites.[89,90] A few key informants also reported that climate change has exacerbated concerns for food security, which is already high in many regions. The concept of 'solastalgia' has been discussed within the literature as it relates to climate grief experienced by many Inuit – defined as "a feeling of home sickness without ever leaving home" because of the visible changes to the landscape.[91]

Similarly, a 2018 article published by Dodd et al. suggests that **remote and isolated First Nations can be especially impacted** as opportunities for activities on the land are threatened (e.g., fishing, hunting, harvesting, medicine picking), ice road seasons are shortened, the costs of supplies are inflated, and the threat of

> *"Where once the land supplied all that was necessary to exist, today it no longer does, the weather patterns have changed so much that it is more difficult to engage in land-based programs throughout the whole year."*
>
> *-Peter Ballantyne Cree Nation Health Services, Holistic Health Department*

[89] Middleton, J., Cunsolo, A., Jones-Bitton, A., et al. (2020). ""We're people of the snow:" Weather, climate change, and Inuit mental wellness." *Social Science & Medicine, 262, p.113-137.*

[90] MacDonald, J. P., Willox, A. C., Ford, J. D., et al. (2015). "Protective factors for mental health and well-being in a changing climate: Perspectives from Inuit youth in Nunatsiavut, Labrador." Social Science & Medicine, 141, 133-141.

[91] Indigenous Climate Hub. (2021). "Climate Grief: The Emotional Impact of Climate Change." https://indigenousclimatehub.ca/2021/11/climate-grief-the-emotional-impact-of-climate-change/#:~:text=The%20Inuit%20experience%20of%20%E2%80%9Csolastalgia,for%20worry%20among%20the%20Inuit.

displacement is increasing with more extreme wildfire and flooding.[92]

Key Finding: Climate Change and Population-Specific Considerations

Findings from the evaluation suggest that the effects of evacuations can be magnified **especially for Indigenous youth, Elders, and for individuals who are supported by mental wellness services** (e.g., counselling, substance use and harm reduction services). For instance, a few explained that community members can be relocated to places that can re-activate trauma and that may lack the appropriate continuity of supports. For example, the fallout from wildfire evacuations was documented in media articles following emergencies in Manitoba, Ontario, and Alberta.

For this reason, some felt that **emergency management planning must include a dedicated focus on both community mental wellness and specific considerations for priority populations.**

Despite the significant potential implications of climate change for the MWP, it was not always a direct area of focus among regional FNIHB staff. Some FNIHB-MWP representatives indicated that they supported First Nations and Inuit in the following ways:

- Offering **surge support** in collaboration with Health Emergency Management
- **Collaborating with treatment centres** to develop service plans if evacuations are required
- **Coordinating services**, such as pop-up, wrap-around treatment options for community members

As well, **MWTs and Health and Cultural Support Workers were highlighted by a few representatives as critical to providing supports to displaced community members.**

With that being said, a few regional staff noted that climate change was not a significant area of focus within their role and perceived the program to be sufficiently flexible to enable communities to pivot funding when required. Given increasing attention, several **representatives agreed that coordination and collaboration with Health Emergency Management should increase** and that there were opportunities to work alongside communities in emergency planning.

[92] Dodd, W., Howard, C., Rose, C., et al. (2018). "The summer of smoke: ecosocial and health impacts of a record wildfire season in the Northwest Territories, Canada." *The Lancet Global Health* 6 (2018): S30."

We need to be more proactive to support Nations that we know for a fact will go through a wildfire response, it's yearly for some, so not waiting for the event to happen. So, in terms of resourcing: working on planning with partners, building some type of protocol beforehand on how these sorts of events can be managed and mitigated before it happens. We have a very responsive attitude, but now that we have had a very unprecedented season, we can learn from that and have conversations with Nations to support in preparation for what might happen."

- FNIHB Staff

7.3 Service Transfer

Finding 13: The MWP has taken steps to support self-determination and advance Indigenous control over services; notwithstanding the wide diversity of contexts, some overall barriers and opportunities were identified (i.e., funding, intra-governmental alignment, restoring capacity, partnership building).

Program documents highlight that advancing the vision of self-determination and the return of control over services is a key theme in FNIHB's partnerships with Indigenous leaders, organizations, and communities. Key informants stated that the MWP had aligned with this vision in the following ways:

- The **MWP offered a high degree of autonomy and flexibility** to communities/organizations to plan and deliver services according to their priorities, and which was further enhanced by the Mental Wellness Alignment;
- **Reporting was streamlined, which can ease administrative requirements on communities** (however, as described elsewhere, some challenges with reporting were also identified, including changing templates, burdensome requests from central agencies and, additional reporting requirements that may be added to new funding investments.)
- While not akin to service transfer, **the program was "de-centralized" through locally tailored regional partnership structures**, which prioritize First Nations and Inuit-led decision making regarding how funding is allocated and key priorities
- **Treatment centres were governed through independent boards** and not by ISC, allowing centres to develop unique models and programming
- **Training and workforce development activities were largely managed by Indigenous partners** to encourage Indigenous-led training, restoring capacity, and workforce standards; additionally, research and evaluation activities were increasingly undertaken by partners (e.g., conducting needs assessments, special studies)

At the same time, it was noted that the journey to advancing service transfer was complex, unique to each community, Nation, and/or region, and that there were key barriers that can slow the implementation of this vision. **A lack of adequate, sustained funding was reported as the**

number one factor impeding the advancement of service transfer as lack of sufficient funding limited the extent to which communities could effectively deliver a continuum of services, retain qualified staff, develop stable operations, access training and restore capacity, and engage in long-term planning. Further to this, when funding arrangements are complex, fragmented, and uncertain, communities were less able to develop holistic health programs. Several other factors were identified:

Funding stipulations and reporting accountabilities to central agencies[93] were described by some as inconsistent with ISC's priority for service transfer as these stipulations and accountabilities continued to advance federal government priorities and not those of First Nations and Inuit. Communities/organizations were required to deliver reporting on outcomes that may not be meaningful to them or effective to their decision making.

Internal collaboration and integration between program areas and within the department could be improved to ensure a coordinated and consistent effort in moving toward service transfer. Some felt that ISC was not achieving its goal of transfer due to high risk aversion, differing approaches and perspectives across the department, and a lack of clarity, direction, and communication.

A review from the National Collaborating Centre for Indigenous Health[94] and key informant discussions affirm that while there is not a singular "best practice" approach to advancing service transfer, there are common features and promising practices (see Figure below).

[93] Against efforts within the program to streamline reporting and support communities to enter more flexible agreements, key informants noted a key tension as central agencies are requesting additional data along with western-based performance indicators

[94] Halseth, R. & Murdock, L. (2020). "Supporting Indigenous Self-Determination in Health: Lessons Learned from a review of Best Practices in Health Governance in Canada and Internationally." *National Collaborating Centre for Indigenous Health.* *https://www.nccih.ca/Publications/Lists/Publications/Attachments/317/Ind-Self-Determine-Halseth-Murdoch-EN-web-2020-12-02.pdf*

Figure 4. Illustrations of factors which can advance service transfer based on key informant discussions and the literature

Funding	• Funding models that are adequate, sustainable, flexible, consolidated, and long-term (and which include governance, administration, and true service costs), with simplified criteria
Building Capacity	• "Scalable" self-determination based on capacity • Resourcing and supporting workforce development, health planning, data systems and management • Ongoing technical and administrative support to move to increasingly flexible arrangements
Partnerships	• Partner engagement in planning and policy processes • Intra-departmental collaboration and alignment to reduce siloes and ensure a common approach • Clearly articulated roles and responsibilities between federal, provincial/territorial, and Indigenous governments

7.4 Impacts and Lessons Learned from the COVID-19 Pandemic

Finding 14: The COVID-19 pandemic simultaneously created increased need for, and challenges, to deliver the MWP; but new and flexible resources and innovative practices helped mitigate the impact and provided lessons learned for the future.

Impacts of the COVID-19 Pandemic and Mental Wellness

Reports from partners, literature findings, and key informant interviews point to numerous challenges introduced or compounded by the COVID-19 pandemic. Though, it is important to note that the reported impacts were not universally experienced across all communities or populations. Key overall themes are reported below.

- **Inequities in the social determinants of health:** Key informants in both First Nations and Inuit contexts reported that the **COVID-19 pandemic exacerbated underlying inequities in the social determinants of health**, including insufficient housing, inadequate access to culturally safe health care, food insecurity, systemic racism, poverty, and limited internet and technology access for some First Nations and Inuit in rural, isolated, and remote areas.[95]
- **Service disruptions: Due to physical distancing public health directives, many experienced disrupted access to mental wellness related supports and services**, such as harm reduction and safe supply facilities, group programming, counselling, health and cultural supports, and treatment centre services, though mitigation measures were put in place for several services.[96,97] Correspondingly, this had an impact on those who regularly accessed

[95] Britina, B. (2021). "Covid-19 and Indigenous peoples: From crisis towards meaningful change." https://www.ourcommons.ca/Content/Committee/432/INAN/Reports/RP11143866/inanrp06/inanrp06-e.pdf

[96] Britina, B. (2021). "Covid-19 and Indigenous peoples: From crisis towards meaningful change." https://www.ourcommons.ca/Content/Committee/432/INAN/Reports/RP11143866/inanrp06/inanrp06-e.pdf

[97] First Peoples Wellness Circle. (2021). "Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories."

and relied on programs and also created vulnerability for individuals with substance use disorders.

- **Acuity and complexity of needs:** The COVID-19 pandemic is expected to have **long-lasting impacts on mental wellness through increasing and more complex crises, violence, and disproportionately high deaths from overdose**.[98] First Nations representatives and MWP staff reported that some communities had observed an increase in the acuity and complexity of substance use linked to isolation, stress, and grief. Toxic drug supplies and reduced access to substance use services also created vulnerability as some community members were using alone.[99,100] Within Inuit contexts, a few respondents reported that the COVID-19 pandemic also coincided with increasing substance use, and which could escalate over time.
- **Population impacts: Isolation measures put in place during the COVID-19 pandemic had a triggering impact for some community members as it was reminiscent of colonial policies that restricted the movement of people in and out of their communities.**[101] This re-activated trauma associated with lost connections to family, cultural activities, community, and the land.[102] Several mitigating measures were put into place, such as physically distanced supports, support bundles, on-line resources and activities among many other initiatives. Research findings also suggest that the pandemic had a particular impact on women and youth related to isolation, an increase in family violence, and intimate partner violence as some sheltered in unsafe environments.[103]

Mitigation Strategies

In August 2020, ISC announced $82.5 million in funding to support surge capacity and enable communities to adapt and expand mental wellness services in the context of the COVID-19 pandemic. Funding was also available through the Indigenous Community Support Fund which had mental wellness supports, resources, and services included as an eligible activity. As well, MWP staff reported the following measures during the pandemic:

- **Simplifying funding request templates for communities/organizations** to access needs-based funding;
- **Reducing/deferring administrative and reporting** requirements; and,
- **Temporarily funding access to private treatment** centre beds.

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[98] First Peoples Wellness Circle. (2021). “Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories.”

[99] Britina, B. (2021). “COVID-19 and Indigenous peoples: From crisis towards meaningful change.” https://www.ourcommons.ca/Content/Committee/432/INAN/Reports/RP11143866/inanrp06/inanrp06-e.pdf

[100] Health Canada. (2023). “Horizontal Evaluation of the Canadian Drugs and Substances Strategy (CDSS): Evaluation Report.”

[101] Britina, B. (2021). “Covid-19 and Indigenous peoples: From crisis towards meaningful change.” https://www.ourcommons.ca/Content/Committee/432/INAN/Reports/RP11143866/inanrp06/inanrp06-e.pdf

[102] First Peoples Wellness Circle. (2021). “Indian Residential School (IRS) Resolution Health Support and Cultural Support Program Stories.”

[103]Task Group on Mental Wellness. (2023). “Family Violence Prevention: Recommendations on Supporting Family Violence Prevention and Mental Wellness for Remote and Isolated Indigenous Communities” https://thunderbirdpf.org/wp-content/uploads/2023/12/NPH-Family-Violence-Prevention-Report_EN-WEB.pdf

Efforts were also undertaken by national partner organizations to support the workforce, develop and disseminate resources, and deliver online and virtual supports and resources. Regionally, key informants and documents highlighted innovative and successful adaptations. Often, this included expanding land-based activity offerings and shifting to virtual technologies. The following list provides specific examples of efforts to support continuity of programs and services.

- **Treatment centres:** One treatment centre described offering an online wellness program, which provides cultural teachings, mental health and anxiety support, medicine wheel teachings, mindfulness, goal setting, beading, and aftercare kits. The program was used for people in isolation, for pre-treatment, and for aftercare. Other centres developed telehealth/virtual counselling, stockpiled Naloxone and harm reduction supplies, provided care hampers, and pivoted to land-based programming.[104]

- **Mental Wellness Teams:** According to program documents, teams provided support to communities through a virtual platform that allowed clients to connect with staff for remote and chat-based supports. The platform was also pre-loaded on tablets that Teams could loan to clients. Some Mental Wellness Teams provided face-to-face meetings where permissible in the event of emergencies.[105]

- **Inuit service contexts:** Some Inuit representatives described pivoting funding to create wellness packages for communities and supporting families to participate in activities on the land.

Lessons Learned

The COVID-19 pandemic generated important lessons learned around funding and supporting First Nations and Inuit during health emergencies. Examples are displayed below.

Strengths of the COVID-19 Pandemic Response	Opportunities/Lessons from the COVID-19 Pandemic
• The broad program Terms and Conditions alongside the influx of flexible COVID-19 pandemic funding was important to enabling communities to effectively respond to needs. • First Nations and Inuit representatives noted that FNIHB staff were seen as supportive	• Additional funding addressed existing challenges and supported promising practices, though the time-limited nature, meaning that not all service offerings could continue with core funding despite continued need. • Large funding influx led to considerable carry-over for some and created

[104] Thunderbird Partnership Foundation. (2023). "NNADAP & NYSAP Treatment Centres: Impacts, Innovations, and Responses to COVID-19." https://thunderbirdpf.org/wp-content/uploads/2022/03/nnadap__nysap_treatment_centres_impacts_innovations_and_responses_to_covid-19.pdf

[105] Indigenous Services Canada. (n.d.). "COVID-19 update." https://www.myhealthunit.ca/en/health-topics/resources/diseases/COVID-19/On-line-Resources-for-Indigenous-Communities_Mental-Wellness-and-COVID-19.pdf

through discussing how funding could be repurposed for pandemic needs. • The COVID-19 pandemic was an impetus for greater internal collaboration within the branch (e.g., initiation of regional interdisciplinary teams) • Needs-based funding approaches were perceived as effective to enabling communities to efficiently access funding.	challenges in advocating for future funding needs.

Understanding that Program funding has gone up substantially with Budget 2021, it's still not enough. The flexibility that we had with COVID funding, to sort of fill the gaps, and any needs based funding to fill the gaps, when that funding went away, we saw an impact universally all around [our region] now that the needs based funding is gone, it's not like our budgets increased.
-FNIHB Staff

8. Conclusions

The evaluation found that the MWP was highly relevant, with the need outstripping the currently available resources. Programs/services funded through the MWP were necessary to address the enduring legacy of settler colonialism and to support good health and well-being for First Nations and Inuit across the lifespan. The program experienced growing demands for supports due to many factors, including continued growing need, the COVID-19 pandemic, the toxic drug supply and continuing overdose crisis, and greater dialogue and awareness of mental wellness and the experiences of Survivors of colonial trauma.

Changes were made to the MWP's design to respond to priorities for increasingly flexible funding. For example, the Mental Wellness Alignment provided increased flexibility in funding to support communities and organizations to plan, deliver, and adapt programs in-line with their unique and evolving priorities The MWP also received funding enhancements in priority areas, such as the expansion of MWTs, funding for Inuit suicide prevention, greater resources for treatment centres, and the renewal and expansion of supports for Survivors and Intergenerational Survivors of the IRS, Federal Indian Day Schools, and those affected by the tragedy of Missing and Murdered Indigenous Women and Girls.

Qualitatively, findings indicate that MWP-funded programs were responsive to the unique needs of First Nations and Inuit as the program supported the integration of culture, trauma-informed and strengths-based approaches, and the evolution of services and supports over time (e.g., during the COVID-19 pandemic). Findings from Phase One suggest that while these services were contributing to a continuum of care, challenges remained across regions in ensuring a comprehensive system of supports. These included challenges in access to culturally safe medical detox services (provincially delivered), case management, and treatment centres and community addictions programming. Key factors that appeared to affect a coordinated mental wellness system included lack of provincial partnership and investment, need for additional funding, human resource capacity, and limited facilities/infrastructure in some communities. However, the absence of community-level engagement during the Phase One data gathering phase limited the assessment of impacts and gaps in programming and within the broader system of mental wellness supports.

Despite program enhancements (e.g., 56% increase in contributions spending), there was strong agreement that the available financial resources within the program did not enable First Nations and Inuit to meet the demand for services as funding had not kept pace with factors including population growth, inflation, competitive wages, and increasing program demand. Furthermore, key informants indicated that more than half of total funding was time-limited and did not include an escalator. According to key informants (including regional partners), limited funding constrained the extent to which communities could invest in prevention, move towards service transfer, and support key populations (e.g., children, youth, families).

Alongside improving funding approaches, key informants recommended enhancing support for the mental wellness workforce in collaboration with national partner organizations such as through

a dedicated workforce strategy, mentorship and laddered training, and focusing on knowledge sharing.

Finally, the evaluation found that support offered through the MWP could be improved through addressing internal management concerns (e.g., turnover, misplaced funding reports), strengthening communication (e.g., related to the Alignment), focusing on consistency in reporting requirements, and improving intra-departmental collaboration. While the creation of ISC fostered alignment and a common vision, key informants felt that opportunities to collectively advance key issues (e.g., the social determinants of health, children and youth, emergency management planning) had not been maximized. Given the multi-faceted and complex nature of mental wellness, effective partnerships (with First Nations and Inuit, nationally, and regionally) were greatly needed to advance progress and improve outcomes.

9. Phase One Recommendations

Based on findings that emerged through Phase One of the evaluation, the following recommendations were identified.

1. **Indigenous partner-led Phase Two Study:** ISC should support an Indigenous-led second phase of study that focuses on First Nations and Inuit community voices that were not captured within Phase One.

   As community-based perspectives were not gathered in the current evaluation study, it will be important to engage with funded communities/organizations. who reflect a wide diversity of contexts, in order to gain a comprehensive understanding of the MWP and its future directions. This second phase of study should complement the regular engagements that program officials undertake with Indigenous partners, and focus on areas in which additional information from community perspectives is most needed, such as those not covered in recent Indigenous-led studies.

2. **Collaboration:** ISC should review and identify measures to advance a) intra-departmental; and b) regional collaboration to better address the complex and multi-faceted challenges present within mental wellness (e.g., the social determinants of health, Health Emergency Management planning, children and youth).

   Findings from Phase One point to the complex and multi-faceted nature of mental wellness (Finding 1) and the coordination challenges within the department and regionally (i.e., between FNIHB, First Nations and Inuit partners, and provincial and territorial representatives) (Finding 4,7,9,11). Exploring opportunities to increase intra-departmental (i.e., horizontal) collaboration to focus on coordinated action could support advancement of key issues identified in Phase One (e.g., social determinants of health, Health Emergency Management, children and youth). Further to this, continuing to advance coordinated and collaborative regional partnerships (i.e., with First Nations and Inuit regional partners and provincial and territorial health system representatives) is important to collectively addressing gaps in the continuum of mental wellness services, reducing duplication, and achieving progress in reducing health inequities.

3. **Funding:** ISC should develop options for overcoming the program delivery challenges created by restrictions on capital spending and revisit and update as required the program's funding approaches, including with respect to the need for sufficient ongoing funding with appropriate escalators, and the appropriate distribution of available funds. .

   Funding remained a key barrier to meeting demand and achieving outcomes (Finding 8). Several issues were outlined by key informants: funding had not kept pace with needs, some restrictions (i.e., capital) limited the delivery of programs, not all funding included growth, and the time-limited nature of funding did not enable sustainable planning and delivery. Therefore, there is a great need to continue to focus on, and advocate for, funding that is adequate,

sustainable, equitable, flexible (including: facility/capital needs), and long-term and which supports First Nations and Inuit to advance their priorities.

4. **Workforce development:** ISC should work collaboratively with First Nations and Inuit partners to explore opportunities/mechanisms that could further support workforce development and support an updated assessment of the impacts of competitive wages on workforce development and retention.

   Findings from Phase One suggest that supporting the mental wellness workforce that supports communities is an area of priority and aligns with the broader vision of supporting service transfer (Finding 8,12). The creation of a mental wellness workforce strategy, mentorship programs and laddered training delivered through a First Nations and Inuit lens could be opportunities for further exploration in this area. Additionally, greater insight on wages and compensation could augment ISC's ability to recruit and retain mental wellness professionals.

5. **Performance measurement:** ISC should work collaboratively with partners to identify opportunities to align performance measurement activities with community perspectives on wellness, ensure alignment between the logic model and program indictors, and continue to fund partner-led assessments to gather meaningful data (e.g., on important topics, issues, and population-specific considerations within the MWP) (Finding 10).

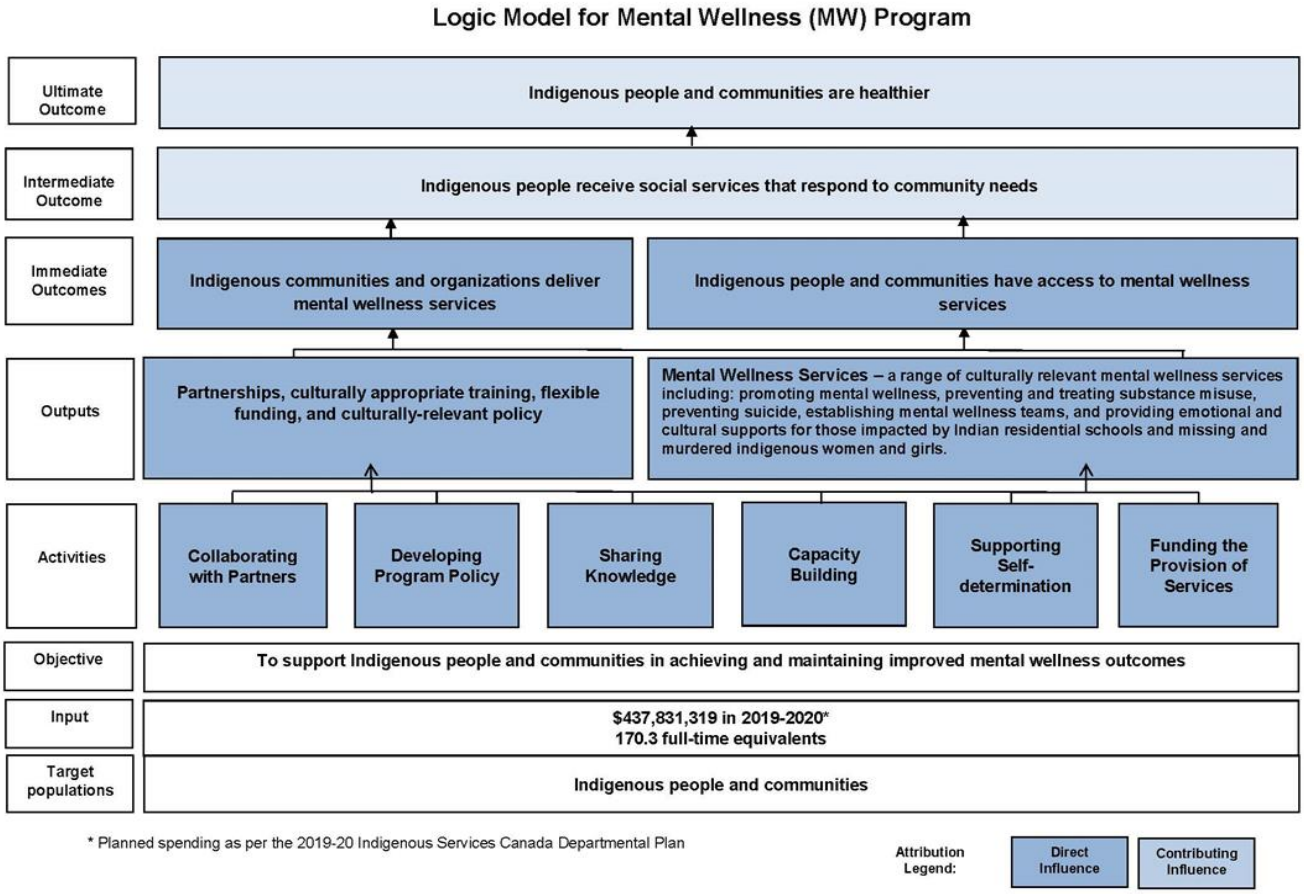
   Working alongside First Nations and Inuit partners, performance measurement could be enhanced within the program through approaches that are culturally safe, trauma-informed, and in-line with distinction-based perspectives on wellness. Collaboration in this area, as well as resources, could improve the capacity of community-based staff to ensure adequate data systems, processes and strategies are in place to collect and use meaningful data. Attention should also be placed on improving the clarity and alignment of the logic model, including the linkages between program activities, indicators and expected outcomes. A consistent logic model and indicator use, in addition to the associated reporting templates and data collection tools, can facilitate measurement. As well, it is recommended that the MWP continue to fund partner-led assessments, which could contribute to improving outcomes.

Appendix A: MWP Funding Investments

The table below outlines funding investments announced during the evaluation timeframe.

Source	Amount	Funded Activities
2016 Interim Measures	$69M over 3 years	• MW Teams • Crisis response capacity • Hope for Wellness Help Line • ITK's National Inuit Suicide Prevention Strategy
Budget 2017	$118M over 5 years, $42M per year ongoing	• Continued support for MW Teams and the Hope for Wellness Line • Community-identified priorities in MW • Youth Hope Fund
	$15M over 5 years, $4M per year ongoing	• Renewed Canadian Drugs and Substances Strategy • Wraparound services at opioid agonist sites • Bulk purchase/distribution of Naloxone to communities
Budget 2018	$200M over 5 years, $40M per year ongoing	• Enhanced delivery of culturally appropriate substance use treatment and prevention services in communities with high needs
	$248M over 3 years	• Renewal of the Indian Residential Schools Resolution Health Support Program
2018	$21.3M over 3 years	• Response to the June 2018 Missing and Murdered Indigenous Women and Girls Interim Report • Health and cultural supports for those affected by the issue of Missing and Murdered Indigenous Women and Girls
Budget 2019	$50M over 10 years, $5M per year ongoing	• Continued implementation of ITK's National Inuit Suicide Prevention Strategy
Budget 2020	$17.1M over 1 year	• Continued health and cultural supports for those affected by the issue of MMWIG (bridge funding until 2021) • Access to trauma-informed health and cultural supports and mental health counselling for former students of federal Indian Day Schools and their families
2020	$82.5M	• Support for Indigenous communities to adapt and expand MW services to improve access and address growing demand within the context of the COVID-19 pandemic

Appendix B: Logic Model



Appendix C: Evaluation Issues and Questions

The evaluation questions below were used to guide Phase One of the evaluation. The questions were designed by the ISC Evaluation Department and used to engage a third-party evaluator to conduct the evaluation.

Relevance

1. To what extent does the MWP support First Nations and Inuit to address mental wellness needs?
    a. How does the MWP understand the needs of communities, and how is this information used?
    b. Do flexible funding models help address needs?
    c. Is community capacity sufficient to address needs?

2. To what extent is the funding and support of the MWP aligned to the needs and priorities of First Nations, and of Inuit?

Design and Delivery

3. To what extent has the MWP effectively supported funded regional organizations and communities to deliver mental wellness services?
    a. To what extent are partners and communities using flexible funding through flexible agreements (e.g., Block Agreements) and the Mental Wellness Alignment to meet community needs and priorities?
        i. How effective are flexible funding arrangements (e.g., policies, agreement types) in supporting organizations and communities?
    b. How could support be improved?

4. How has the creation of ISC affected mental wellness program delivery and achievement of outcomes?

5. How ready is the MWP for the eventual transfer of services?
    a. How has the MWP worked towards ensuring the eventual transfer of departmental responsibilities to First Nations and Inuit, as mandated by the Department? (e.g., what processes, policies, partnerships are in place?)
    b. Where can the MWP improve in its work toward service transfer? (e.g., barriers related to legislative; regulatory; rigidity of Terms and Conditions; skills and resource development; workforce supports, training, and pay equity; funding; reporting)
    c. What opportunities exist to support the eventual transfer of services?

6. Are there any beneficial or harmful unintended consequences associated with the MWP's work in how they support and fund First Nations and Inuit to design, deliver, and implement mental wellness services?

Effectiveness

7. To what extent has the MWP made progress toward its intended outcomes (immediate, intermediate, and ultimate level)?
    a. Immediate outcome:
        i. First Nations and Inuit communities and organizations deliver MW services
        ii. First Nations and Inuit people and communities have access to MW services
    b. Intermediate outcome: First Nations and Inuit people receive health and social services that respond to community needs
    c. Ultimate outcome: First Nations and Inuit people and communities are healthier
    d. Are there other unfunded activities/services that would support the MWP to progress toward its intended outcomes?

8. What aspects of the MWP are working well and what aspects need improvement?
    a. What factors (internal and external) are influencing the MWP's performance?

9. What access do First Nations and Inuit peoples have to a continuum of culturally safe mental wellness services across the lifespan?
    a. How has it changed over the evaluation time period?
    b. Are there population-specific gaps to accessing a continuum of culturally mental wellness services? (e.g., regional/geographic, distinctions, across the lifespan, gender and sexual identity (2SLGBTQI+))?

10. To what extent has the MWP partnered and collaborated with key partners (First Nations and Inuit partners, provincial and territorial governments) to inform the MWP?
    a. How can the MWP improve on partnerships and collaboration with Inuit and First Nations partners, and with provincial and territorial governments?

Efficiency

11. How cost effective is the design and delivery of the MWP? How could it be more cost-effective?
    a. Does the MWP allocate funding and resources based on identified priorities?
    b. Is funding for the MWP appropriate and sufficient to meet expected outcomes?

12. What impact has the COVID-19 pandemic had on the MWP?
    a. What steps have been taken to the MWP to mitigate the effects of the COVID-19 pandemic (e.g., impacts related to public health measures, increase in service requests)?

13. What lessons have been learned from the pandemic regarding the strengths and/or challenges of the MWP in dealing with major external disruptions?

14. How does the MWP consider climate change impacts when supporting and funding communities? (e.g., health emergency management)

Appendix D: Evaluation Methodology and Analytical Approach

Literature Review

The evaluation team reviewed existing literature exploring First Nations and Inuit mental wellness to make the best use of previous and current knowledge in the field – including both peer-reviewed (scientific and academic) and grey literature (relevant media articles and websites) from a variety of sources (e.g., National Collaborating Centre for Indigenous Health, relevant publication, resources from Indigenous and community-based groups). The review informed the assessment of program relevance (i.e., current landscape of the need/demand for mental wellness services, Inuit and First Nations priorities as they relate to mental wellness, gaps in services) as well as issues including health governance/service transfer, COVID-19 impacts, and First Nations and Inuit perspectives on climate change (as it relates to mental wellness). Literature sources were gathered based on existing work conducted by ISC Evaluation, and further informed by input from the EAG. Additional literature was also included based on a review of references in reports/documents, as well as a targeted key word search.

Document and Data Review

A review of program documents and files was undertaken to help understand the context (foundational frameworks), governance, and delivery structure of the MWP as well as what has been accomplished to date with respect to objectives and goals. The review also leveraged existing work that has been conducted by program partners (i.e., First Nations and Inuit organizational partners), such as previous evaluations, needs assessments, and other research reports in order to reduce duplication and burden. Resources for the document review were sought from the Program and identified alongside Inuit and First Nations partners in discussions.

Examples of key resources leveraged in the document review included:

- Partner frameworks (First Nations Mental Wellness Continuum Framework, Honouring our Strengths, National Inuit Suicide Prevention Strategy)[106]
- Truth gathering reports (Truth and Reconciliation Commission of Canada Report; National Inquiry into Missing and Murdered Indigenous Women and Girls Report)
- Annual MW program plans
- Program performance data (i.e., Performance Information Profile, reporting roll-up data from the CBRT, Treatment Centre Reporting, IRS/MMIWG/IDS Reporting)
- Program update dashboards (e.g., Opioid dashboards)

[106] While the evaluation was required to align with the *Policy on Results,* the evaluation team strived to consider the overall thematic priority areas and concepts as discussed in the FNMWC, HOS and the NISPS (e.g., a continuum of culturally safe services, enablers/supporting factors of mental wellness programming, the importance of culture as the foundation of care, distinctions-based and community-led approaches) as the vision identified by First Nations and by Inuit for mental wellness programs. These guiding and foundational concepts were considered when coding/reviewing the interview data, literature, and documentation. However, this can not imply that the frameworks provided the basis theory for the evaluation.

- Departmental plans and FNIHB Strategic Plans
- Financial data (i.e., total allocations and expenditures)
- Treasury board submissions
- Partner reports (e.g., annual reports, research/evaluation reports, advocacy papers)
- Previous evaluation reports for the MWP and related initiatives (e.g., National Anti-Drug Strategy)
- Reports of the Office of the Auditor General
- Web pages/online articles relevant to the MWP (e.g., ISC MW, partner websites)

Key Informant Interviews

The key informant interviews were completed as part of the initial evaluation to gain a comprehensive understanding of the MWP in-line with the evaluation questions and to identify key priorities, issues, and themes which could be of interest in a follow up Phase Two. Interviews were held from October to December 2023 via videoconferencing software and by telephone where requested. Participants were provided with the question guide in advance of the interview and were made aware that the interview data provided would be held confidential, voluntary, and that their responses would be summarized in an aggregate format with the other respondents and data. Interviews were recorded with the consent of participants and securely stored by Ference & Company. All participants were also asked to indicate their preference for whether the interviews were attended by ISC Evaluation representatives (alternatively, solely led by the contractor).

A multi-pronged sampling approach was utilized. Known contacts for the evaluation were provided through ISC national office staff, to include national and regional office staff, as well as national partner organizations. In addition, a multi-pronged snowball sampling technique was used in an effort to promote a balanced perspective of the MWP between internal (federal) and external (First Nations and Inuit) representatives. The following activities were undertaken to gather additional contacts for Phase One interviews:

- Attendance and networking at in-person Mental Wellness Summit Gathering
- Virtual introductions and presentations at committee meetings, including the AFN Mental Wellness Committee and the FNIHB Regional Cluster Meeting
- Follow-up with national First Nations and Inuit partner organizations
- Follow-up with all FNIHB Regional Office representatives

Analytical Approach

Each line of evidence (i.e., document review, literature review, key informant interviews) was analyzed separately using appropriate qualitative and/or quantitative techniques and organized by evaluation question or sub-question. Findings were subsequently developed by reviewing all available evidence for each question and across all lines of evidence, considering the relative strengths and limitations of each data source/method and any gaps/contradictions in findings, and weighting/qualifying findings accordingly.

The data gathered through the interviews were cleaned, coded, and analyzed against the evaluation issue, question, and sub-question using a thematic analysis approach and summarized

by stakeholder group where applicable. Throughout the analysis, the relative strengths and limitations associated with the responses were considered; for instance, the “weight” of the data was considered according to the knowledge level of respondents with respect to the issue/question, the extent of their interactions/involvement with First Nations and Inuit communities/organizations delivering services, and the level of supporting details/examples provided through their feedback. An inductive and deductive approach was utilized to code the responses.

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